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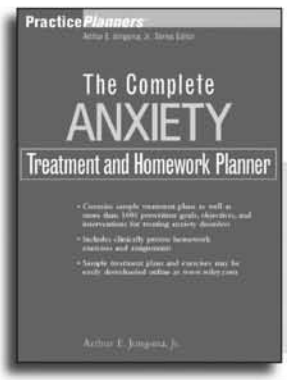
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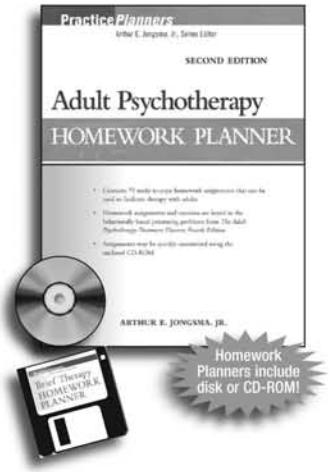
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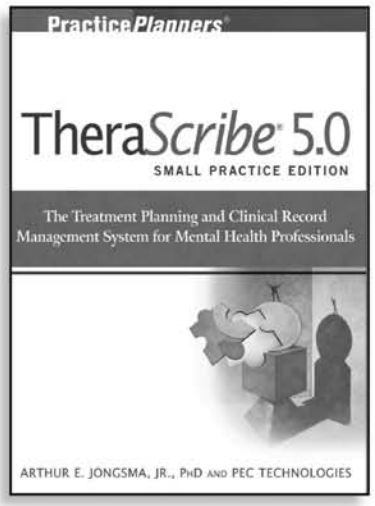
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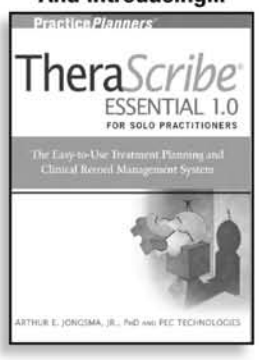
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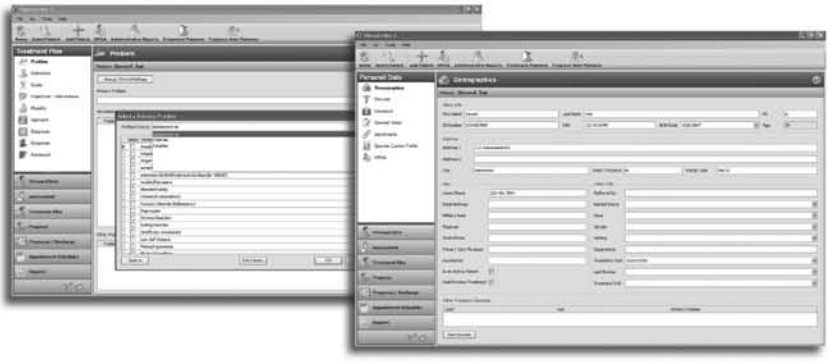
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Robert R. Perkinson

Arthur E. Jongsma, Jr.

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To Helen Kramer, who has been a dedicated, tireless, behind-the-scenes warrior for disenfranchised folks struggling with mental illness and addictions.

—A.E.J.

To Shane, Nyshie, and Robert, three of the world-changing best.

—R.R.P.

To all of those who struggle with addiction, and those who dedicate their lives in service to them.

—T.J.B.

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- ***Client Education Handout Planners*** provide brochures and handouts to help educate and inform clients on presenting problems and mental health issues, as well as life skills techniques. The handouts are included on CD-ROMs for easy printing from your computer and are ideal for use in waiting rooms, at presentations, as newsletters, or as information for clients struggling with mental illness issues. The topics covered by these handouts correspond to the presenting problems in the *Treatment Planners*.

The series also includes:

- **Thera*Scribe*®**, the #1 selling treatment planning and clinical record-keeping software system for mental health professionals. Thera*Scribe*® allows the user to import the data from any of the *Treatment Planner*, *Progress Notes Planner*, or *Homework Planner* books into the software's expandable database to simply point and click to create a detailed, organized, individualized, and customized treatment plan along with optional integrated progress notes and homework assignments.

Adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook*, contain forms and resources to aid the clinician in mental health practice management.

The goal of our series is to provide practitioners with the resources they need in order to provide high quality care in the era of accountability. To put it simply: We seek to help you spend more time on patients, and less time on paperwork.

ARTHUR E. JONGSMA, JR.
Grand Rapids, Michigan

INTRODUCTION

ABOUT PRACTICEPLANNERS® TREATMENT PLANNERS

Pressure from third-party payors, accrediting agencies, and other outside parties has increased the need for clinicians to quickly produce effective, high-quality treatment plans. *Treatment Planners* provide all the elements necessary to quickly and easily develop formal treatment plans that satisfy the needs of most third-party payors and state and federal review agencies.

Each *Treatment Planner*:

- Saves you hours of time-consuming paperwork.
- Offers the freedom to develop customized treatment plans.
- Includes over 1,000 clear statements describing the behavioral manifestations of each relational problem, and includes long-term goals, short-term objectives, and clinically tested treatment options.
- Has an easy-to-use reference format that helps locate treatment plan components by behavioral problem or DSM-IV-TR diagnosis.

As with the rest of the books in the Practice*Planners*® series, our aim is to clarify, simplify, and accelerate the treatment planning process, so you spend less time on paperwork, and more time with your clients.

ABOUT THE ADDICTION TREATMENT PLANNER

The *Addiction Treatment Planner* has been written for individual, group, and family counselors and psychotherapists who are working with adults who are struggling with addictions to mood-altering chemicals, gambling, abusive eating, nicotine, or sexual promiscuity. The problem list of chapter titles reflects those addictive behaviors and the emotional, behavioral, interpersonal, social, personality, legal, medical, and vocational issues associated with those addictions. Whereas the focus of the original *Chemical Dependence Treatment Planner* was limited exclusively to substance abuse and its associated problems,

the focus of later editions has been expanded to include other common addictive behaviors. The original problem chapters have been altered slightly from the first edition to be more generic in their language so as to include these other addictions.

This fourth edition has added chapters for Conduct Disorder and Adult Attention-Deficit/Hyperactivity Disorder (Adult ADHD). The Conduct Disorder chapter is relevant to late childhood and adolescent clients showing problem behaviors consistent with this diagnosis such as aggression, lying, and impulsivity. It includes short-term objectives and treatment intervention options consistent with identified empirically supported treatments for conduct problems such as parent training, assertiveness training, and anger control training with stress inoculation (for more information see the website of the Society of Clinical Child and Adolescent Psychology, Division 53 of the American Psychological Association at http://sccap.tamu.edu/EST/). The Adult ADHD chapter has been added to capture this increasingly frequent presenting problem, and includes short-term objectives and treatment intervention options consistent with the cognitive behavior treatment approach that has received empirical support (e.g., Safren, Otto, Sprich, Winett, Wilens, & Biederman, 2005).

This edition of the *Addiction Treatment Planner* continues to give special attention to the Patient Placement Criteria (PPC) developed by the American Society of Addiction Medicine (ASAM). In the Contents table we have listed our presenting problem chapters under each of the six assessment dimensions:

Dimension One: Acute intoxication and/or withdrawal potential

Dimension Two: Biomedical conditions and complications

Dimension Three: Emotional, behavioral, or cognitive conditions and complications

Dimension Four: Readiness to change

Dimension Five: Relapse, continued use, or continued problem potential

Dimension Six: Recovery/Living environment

The *Addiction Treatment Planner* has treatment planning content applicable to problems discovered in all of the six assessment dimensions.

Also included (Appendix E) is a form that can be used to assess the client under the six ASAM dimensions. The checklist provides material for efficient evaluation of the client on each of the six dimensions. This form has been developed and is utilized by the staff at Keystone Treatment Center, Canton, South Dakota, where Dr. Perkinson is the Clinical Director. It is not copyrighted and may be used or adopted for use by our readers.

Interventions can be found in each chapter that reflect a 12-step recovery program approach, but you will also find interventions based on a broader psychological and pharmacological model. Because addiction treatment is often done in a residential setting through a team approach, interventions have been created that can be assigned to staff members of various disciplines and modalities: nursing, medical, group counseling, family therapy, or individual

which has been well established as an empirically supported treatment for depression. Beyond references to the empirical studies supporting these interventions, we have provided references to therapist- and client-oriented books and treatment manuals that describe the use of identified EBPs or treatments consistent with their objectives and interventions. Of course, recognizing that there are STOs and TIs that practicing clinicians have found useful but that have not yet received empirical scrutiny, we have included those that reflect common best practice among experienced clinicians. The goal is to provide a range of treatment plan options, some studied empirically, others reflecting common clinical practice, so the user can construct what they believe to be the best plan for a particular client.

In chapters containing EBP material, the material, in most cases, has been placed after STOs and TIs addressing the substance-related or other addictive problems that may be present. The current emphasis on co-occurring disorders encourages clinicians to treat substance use disorders and mental illness problems simultaneously. An exception to this sequencing is when therapeutic issues related to establishing the safety of the client or others take precedence. In addition, some EBP-related STOs and TIs reflect core components of the EBP approach that are always delivered (e.g., exposure to feared objects and situations for phobic disorders; behavioral activation for depression). Others reflect adjuncts to treatment that may or may not be used all the time (e.g., social and other communication skills, stress management skills). For the EBPs that are more programmatic in nature, such as supported employment, STOs and TIs typically refer the client to these programs. Most of the STOs and TIs associated with the EBPs are described at a level of detail that permits flexibility and adaptability in their specific application. As with all *Planners* in this series, each chapter includes the option to add STOs and TIs at the therapist's discretion.

Criteria for Inclusion of Evidence-Based Therapies

The EBPs from which STOs and TIs were taken have different levels of empirical evidence supporting them. For example, some have been well established as efficacious for the problems that they target (e.g., exposure-based therapies for anxiety disorders). Others have less support, but nonetheless have demonstrated efficacy. We have included EBPs, the empirical support for which has either been well established or demonstrated at more than a preliminary level, as defined by those authors who have undertaken the task of identifying them, such as the APA Division 12 (Society of Clinical Psychology), the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices, Drake and colleagues (2003, 2005), Chambless and colleagues (1996, 1998), and Nathan and Gorman (2007).

At minimum, efficacy needed to be demonstrated through a clinical trial or large clinical replication series with features reflecting good experimental design (e.g., random assignment, blind assignments, reliable and valid measurement,

clear inclusion and exclusion criteria, state-of-the-art diagnostic methods, and adequate sample size or replications). Well established EBPs typically have more than one of these types of studies demonstrating their efficacy, as well as other desirable features such as demonstration of efficacy by independent research groups and specification of client characteristics for which the treatment was effective.

Lastly, all interventions, empirically supported or not, must be adapted to the particular client in light of his/her personal circumstances, cultural identity, strengths, and vulnerabilities. The STOs and TIs included in this *Planner* are written in a manner to suggest and allow this adaptability.

Summary of Required and Preferred SPMI EBT Inclusion Criteria

Required

- Demonstration of efficacy through at least one randomized controlled trial with good experimental design, or
- Demonstration of efficacy through a large, well-designed clinical replication series.

Preferred

- Efficacy has been shown by more than one study.
- Efficacy has been demonstrated by independent research groups.
- Client characteristics for which the treatment was effective were specified.
- A clear description of the treatment was available.

HOW TO USE THIS TREATMENT PLANNER

Use this *Treatment Planner* to write treatment plans according to the following progression of six steps:

1. **Problem Selection.** Although the client may discuss a variety of issues during the assessment, the clinician must determine the most significant problems on which to focus the treatment process. Usually a primary problem will surface, and secondary problems may also be evident. Some other problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can only deal with a few selected problems or treatment will lose its direction. Choose the problem within this *Planner* which most accurately represents your client's presenting issues.
2. **Problem Definition.** Each client presents with unique nuances as to how a problem behaviorally reveals itself in his or her life. Therefore, each problem

that is selected for treatment focus requires a specific definition about how it is evidenced in the particular client. The symptom pattern should be associated with diagnostic criteria and codes such as those found in the *DSM-IV-TR* or the *International Classification of Diseases*. This *Planner* offers such behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements.

3. **Goal Development.** The next step in developing your treatment plan is to set broad goals for the resolution of the target problem. These statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures. This *Planner* provides several possible goal statements for each problem, but one statement is all that is required in a treatment plan.
4. **Objective Construction.** In contrast to long-term goals, objectives must be stated in behaviorally measurable language so that it is clear to review agencies, health maintenance organizations, and managed care organizations when the client has achieved the established objectives. The objectives presented in this *Planner* are designed to meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem.
5. **Intervention Creation.** Interventions are the actions of the clinician designed to help the client complete the objectives. There should be at least one intervention for every objective. If the client does not accomplish the objective after the initial intervention, new interventions should be added to the plan. Interventions should be selected on the basis of the client's needs and the treatment provider's full therapeutic repertoire. This *Planner* contains interventions from a broad range of therapeutic approaches, and we encourage the provider to write other interventions reflecting his or her own training and experience.

   Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix A contains a full bibliographic reference list of these materials. Many references to homework interventions are found in each chapter; The sources for these assignments can be found in the books listed in the General References at the beginning of Appendix A. For further information about self-help books, mental health professionals may wish to consult *The Authoritative Guide to Self-Help Resources in Mental Health, Revised Edition* (2003) by Norcross et al. (available from The Guilford Press, New York).
6. **Diagnosis Determination.** The determination of an appropriate diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents with the criteria for diagnosis of a mental illness condition as described in *DSM-IV-TR*. Despite arguments made against diagnosing clients in this manner, diagnosis is a reality that exists in the world of mental health care, and it is a necessity for third-party

therapy. We hope that we have provided a broad, eclectic menu of objectives and interventions from which you can select to meet your client's unique needs. Hopefully, we have also provided a stimulus for you to create new objectives and interventions from your own clinical experience that have proven to be helpful to addictive clients.

INCORPORATING EVIDENCE-BASED TREATMENT INTO THE TREATMENT PLANNER

Evidence-based or empirically supported treatment (that is, treatment that has shown efficacy in research trials) is rapidly becoming of critical importance to the mental health community as the demand for quality and accountability increase. Indeed, identified empirically supported treatments (e.g., those of the APA Division 12 [Society of Clinical Psychology], the Substance Abuse and Mental Health Services Administration's [SAMHSA] National Registry of Evidence-based Programs and Practices [NREPP] are being referenced by a number of local, state, and federal funding agencies, some of which are beginning to restrict reimbursement to these treatments, as are some managed care and insurance companies.

In this fourth edition of *The Addiction Treatment Planner,* we have made an effort to empirically inform some chapters by highlighting Short-term Objectives (STOs) and Therapeutic Interventions (TIs) that are consistent with psychological treatments or therapeutic programs that have demonstrated some level of efficacy through empirical study. Watch for this icon [EBP] as an indication that an Objective/Intervention is consistent with those found in evidence-based treatments.

References to the empirical work supporting these interventions have been included in the reference section as Appendix B. For information related to the identification of evidence-based practices (EBPs), including the benefits and limitations of the effort, we suggest the APA Presidential Task Force on Evidence-Based Practice (2006); Bruce and Sanderson (2005); Chambless et al. (1996, 1998); Chambless and Ollendick (2001); Castonguay and Beutler (2006); Drake, Merrens, and Lynde (2005); Hofmann and Tompson (2002); Nathan and Gorman (2007); Stout and Hayes (2005); the NREPP at http://nrepp.samhsa.gov/index.asp.

In this *Planner*, we have included STOs and TIs consistent with identified EBPs for substance-related and mental disorders commonly seen by practitioners in substance use disorder treatment centers. It is important to note that the empirical support for the EBP material found in each chapter has not necessarily been established for clients with co-occurring substance and mental disorders, but rather is particular to the problem identified in the chapter title. For example, the STOs and TIs consistent with Cognitive Therapy for Depression that can be found in the chapter entitled "Depression" are based on this treatment approach,

reimbursement. It is the clinician's thorough knowledge of *DSM-IV-TR* criteria and a complete understanding of the client assessment data that contribute to the most reliable, valid diagnosis.

Congratulations! After completing these six steps, you should have a comprehensive and individualized treatment plan ready for immediate implementation and presentation to the client. A sample treatment plan for substance abuse-dependence is provided at the end of this introduction.

A FINAL NOTE ON TAILORING THE TREATMENT PLAN TO THE CLIENT

One important aspect of effective treatment planning is that each plan should be tailored to the individual client's problems and needs. Treatment plans should not be mass-produced, even if clients have similar problems. The individual's strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns *must* be considered in developing a treatment strategy. Drawing upon our own years of clinical experience, we have put together a variety of treatment choices. These choices can be combined in thousands of permutations to develop detailed treatment plans. Relying on their own good judgment, clinicians can easily select the statements that are appropriate for the individuals whom they are treating. In addition, we encourage readers to add their own definitions, goals, objectives, and interventions to the existing samples. As with all of the books in the *Treatment Planners* series, it is our hope that this book will help promote effective, creative treatment planning – a process that will ultimately benefit the client, clinicians, and mental health community.

REFERENCES

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271–285.

Bruce, T. J., & Sanderson, W. C. (2005). Evidence-based psychosocial practices: Past, present, and future. In C. Stout and R. Hayes (Eds.), *The handbook of evidence-based practice in behavioral healthcare: Applications and new directions*. New York: John Wiley & Sons, Inc.

Castonguay, L. G., & Beutler, L. E. (2006). *Principles of therapeutic change that work.* New York: Oxford University Press.

Chambless, D. L., Baker, M. J., Baucom, D., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., Daiuto, A., DeRubeis, R., Detweiler, J., Haaga, D. A. F., Johnson, S. B., McCurry, S., Mueser, K. T., Pope, K. S., Sanderson, W. C., Shoham, V., Stickle, T., Williams, D. A., & Woody, S. R. (1998). Update on empirically validated therapies: II. *The Clinical Psychologist*, *51*(1), 3–16.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685–716.

Chambless, D. L., Sanderson, W. C., Shoham, V., Johnson, S. B., Pope, K. S., Crits-Christoph, P., Baker, M., Johnson, B., Woody, S. R., Sue, S., Beutler, L., Williams, D. A., & McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49*(2), 5–18.

Drake, R. E., & Goldman, H. (2003). *Evidence-based practices in mental health care.* Washington, D.C.: American Psychiatric Association.

Drake, R. E., Merrens, M. R., & Lynde, D. W. (2005). *Evidence-based mental health practice: A textbook*. New York: W.W. Norton & Company.

Hofmann, S. G., & Tompson, M. G. (2002). *Treating chronic and severe mental disorders: A handbook of empirically supported interventions.* New York: Guilford Press.

Nathan, P. E., & Gorman, J. M. (Eds.). (2007). *A guide to treatments that work* (Vol. III). New York: Oxford University Press.

Safren, S. A., Otto, M. W., Sprich, S., Winett, C. L., Wilens, T. E., & Biederman, J. (2005). Cognitive-behavioral therapy for ADHD in medication-treated adults with continued symptoms. *Behaviour Research and Therapy, 43*(7), 831–842.

Stout, C., & Hayes, R. (1995). *The handbook of evidence-based practice in behavioral healthcare: Applications and new directions*. New York: John Wiley & Sons, Inc.

Substance Abuse and Mental Health Administration (SAMHSA). National Registry of Evidence-based Programs and Practices (NREPP) at http://nrepp.samhsa.gov/index.asp.

SAMPLE TREATMENT PLAN

PRIMARY PROBLEM: SUBSTANCE ABUSE/DEPENDENCE

Definitions: Demonstrates a maladaptive pattern of substance use, manifested by increased tolerance and withdrawal.

Fails to stop or cut down use of mood-altering drug once started, despite the verbalized desire to do so and the negative consequences continued use brings.

Denies that chemical dependence is a problem despite feedback from significant others that the use of the substance is negatively affecting them and others.

Experiences frequent blackouts when using.

Continues substance use despite knowledge of experiencing persistent physical, legal, financial, vocational, social, and/or relationship problems that are directly caused by the use of the substance.

Reports suspension of important social, recreational, or occupational activities because they interfere with using.

Goals: Accept the powerlessness and unmanageability over mood altering substances, and participate in a recovery based program.

Establish and maintain total abstinence, while increasing knowledge of the disease and the process of recovery.

OBJECTIVES

1. Cooperate with medical assessment and an evaluation of the necessity for pharmacological intervention.

INTERVENTIONS

1. Refer the client to a physician to perform a physical examination (include tests for HIV, hepatitis, and sexually transmitted diseases), assess the need for psychotropic medication for any mental/ emotional comorbidities, and discuss the use of acamprosate (Campral), naltrexone (Revia, Vivitrol), or disulfiram (Antabuse) where applicable.
2. Refer the client to a pharmacology-based treatment/recovery program (e.g., acamprosate, naltrexone), where applicable.

2. Take prescribed medications as directed by the physician.	1. Physician will monitor the effectiveness and side effects of medication, titrating as necessary. 2. Staff will administer prescribed medications and monitor for effectiveness and side effects.
3. Provide honest and complete information for a chemical dependence biopsychosocial history.	1. Complete a thorough family and personal biopsychosocial history that has a focus on addiction (e.g., family history of addiction and treatment, other substances used, progression of substance abuse, consequences of abuse).
4. Attend didactic sessions and read assigned material in order to increase knowledge of addiction and the process of recovery.	1. Assign the client to attend a chemical dependence didactic series to increase his/her knowledge of the patterns and effects of chemical dependence; ask him/her to identify several key points attained from each didactic and process these points with the therapist. 2. Assign the client to read a workbook describing evidence-based treatment approaches to addiction recovery (e.g., *Overcoming Your Alcohol or Drug Problem*, 2nd ed. by Daley and Marlatt); use the readings to reinforce key concepts and practices throughout therapy. 3. Assign the client to read material on addiction (e.g., *Willpower's Not Enough* by Washton, *The Addiction Workbook* by Fanning, or *Alcoholics Anonymous*); process key points gained from the reading.
5. List and discuss negative consequences resulting from or exacerbated by substance dependence.	1. Ask the client to make a list of the ways chemical use has negatively impacted his/her life (or assign "Substance Abuse Negative Impact Versus Sobriety's Positive Impact" in the *Adult Psychotherapy*

	Homework Planner, 2nd ed. by Jongsma); process the list in individual or group sessions.
	2. Confront the client's use of denial to minimize the severity of and negative consequences of substance abuse.
	3. Using the biopsychosocial history and the client's list of negative consequences of substance abuse, assist him/her in understanding the need to stay in treatment.
6. List and discuss reasons to work on a plan for recovery from addiction.	1. Assign the client to write a list of reasons to be abstinent from addiction (or assign "Making Change Happen" or "A Working Recovery Plan" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
7. Learn and implement personal coping strategies to manage urges to lapse back into chemical use.	1. Teach the client tailored coping strategies involving calming strategies (e.g., relaxation, breathing), thought-stopping, positive self-talk, and attentional focusing skills (e.g., distraction from urges, staying focused on behavioral goals of abstinence) to manage triggered urges to use chemical substances.
8. Identify, challenge, and replace destructive self-talk with positive, strength building self-talk.	1. Use cognitive therapy approaches to explore the client's schema and self-talk that weaken his/her resolve to remain abstinent; challenge the biases; assist him/her in generating realistic self-talk that correct for the biases and build resilience.
	2. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult*

	Psychotherapy Homework Planner, 2nd ed. by Jongsma); review and reinforce success.
9. Participate in gradual repeated exposure to triggers of urges to lapse back into chemical substance use within individual or group therapy sessions and between them; review with group members and therapist.	1. Direct and assist the client in construction of a hierarchy of urge-producing cues to use substances (or assign "Identifying Relapse Triggers and Cues" or "Relapse Prevention Planning" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz). 2. Select initial *in vivo* or role-played cue exposures that have a high likelihood of being a successful experience for the client; facilitate coping and cognitive restructuring within and after the exposure, use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate the exposure, review with the client and group members, if done in group.
10. Implement relapse prevention strategies for managing possible future situations with high risk for relapse.	1. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse. 2. Using a 12-step recovery program's relapse prevention exercise, help the client uncover his/her triggers for relapse (see *The Alcoholism and Drug Abuse Patient Workbook* by Perkinson). 3. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur. 4. Request that the client identify feelings, behaviors, and situations

that place him/her at a higher risk for substance abuse (or assign "Relapse Triggers" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

DIAGNOSIS

303.9 Alcohol Dependence

ADULT-CHILD-OF-AN-ALCOHOLIC (ACOA) TRAITS

BEHAVIORAL DEFINITIONS

1. Has a history of being raised in an alcoholic home, which resulted in having experienced emotional abandonment, role confusion, abuse, and a chaotic, unpredictable environment.
2. Reports an inability to trust others, share feelings, or talk openly about self.
3. Demonstrates an over-concern with the welfare of other people.
4. Passively submits to the wishes, wants, and needs of others; is too eager to please others.
5. Verbalizes chronic fear of interpersonal abandonment and desperately clings to relationships that can be destructive.
6. Tells other people what they think the other persons want to hear, rather than telling the truth.
7. Verbalizes persistent feelings of worthlessness and a belief that being treated with disrespect and shame is normal and to be expected.
8. Reports strong feelings of panic and helplessness when faced with being alone.
9. Tries to fix other people before concentrating on his or her own needs.
10. Takes on the parental role in a relationship.
11. Reports feeling less worthy than those who have a more normal life.

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LONG-TERM GOALS

1. Implement a plan for recovery from addiction that reduces the impact of adult-child-of-an-alcoholic traits on sobriety.
2. Decrease dependence on relationships while beginning to meet his/her own needs.
3. Reduce the frequency of behaviors that are exclusively designed to please others.
4. Choose partners and friends who are responsible, respectful, and reliable.
5. Overcome fears of abandonment, loss, and neglect.
6. Understand the feelings that resulted in being raised in an ACOA environment and reduce feelings of alienation by learning similarity to others who were raised in a normal home.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Acknowledge the feelings of powerlessness that result from ACOA traits and addiction. (1)	1. Probe the feelings of powerlessness that the client experienced as a child in the alcoholic home, and explore similarities to his/her feelings when abusing chemicals.
2. Verbalize the relationship between being raised in an addictive family and how this behavior is repeated in addiction. (2)	2. Teach the client the relationship between his/her childhood experience in an addictive family and how this increased the likelihood of repeating the addictive behavior pattern as an adult.
3. Complete psychological testing or objective questionnaires for assessing traits associated with being an adult child of an alcoholic. (3)	3. Administer to the client psychological instruments designed to objectively assess the strength of traits associated with being an adult child of an alcoholic (e.g., Symptom Checklist-90-

	Revised [SCL-90-R], Children of Alcoholics Screening Test [CAST]); give the client feedback regarding the results of the assessment.
4. Verbalize the rules of "don't talk, don't trust, don't feel," which were learned as a child, and how these rules have made interpersonal relationships more difficult. (4, 5)	4. Explore how the dysfunctional family rules led to uncomfortable feelings and an escape into addiction. 5. Educate the client about the ACOA rules of "don't talk, don't trust, and don't feel"; explain how these rules make healthy relationships impossible.
5. Verbalize an understanding of how ACOA traits contributed to addiction. (6, 7)	6. Have the client list five ways that ACOA traits led to addiction (or assign the client to complete "Understanding Codependent Behaviors" from the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz). 7. Assist the client in identifying his/her ACOA traits and the relationship between ACOA traits and addiction.
6. Identify the causes of the fear of abandonment that were experienced in the alcoholic home. (8, 9)	8. Probe the client's fear of violence, abandonment, unpredictability, and embarrassment when the parent was mentally unstable or abusing chemicals. 9. Explore specific situations when the client experienced fear of abandonment or feelings of rejection during childhood.
7. Identify how the tendency to take care of others in interpersonal relationships is related to maintaining a feeling of security and control. (10, 11)	10. Assist the client in understanding how his/her early childhood experiences led to fears of abandonment, rejection, neglect, and to an assumption of the caretaker role, which is detrimental to intimate relationships.

11. Assist the client in identifying the many ways in which he/she takes on the parental role of caregiver.

8. Share the feeling of worthlessness that was learned in the alcoholic home, and directly relate this feeling to abuse of substances as a coping mechanism. (12, 13)

12. Explore the client's feelings of worthlessness and shame; assessing specific painful situations.

13. Teach the client how low self-esteem results from being raised in an alcoholic home, due to experiencing emotional rejection, broken promises, abuse, neglect, poverty, and lost social status.

9. List ten reasons for increased feelings of self-worth. (14, 15)

14. Assign the client to list his/her positive traits and accomplishments; reinforce these as a foundation for building self-esteem.

15. Emphasize to the client his/her inherent self-worth as a human being and show the benefits of using a higher power in recovery.

10. Identify the pattern in the alcoholic family of being ignored or punished when honest feelings were shared. (5, 16)

5. Educate the client about the ACOA rules of "don't talk, don't trust, don't feel"; explain how these rules make healthy relationships impossible.

16. Probe how the client's family responded to expressions of feelings, wishes, and wants and why it became dangerous for the client to share feelings with others (or assign the client to complete the "Using the Understanding Family History" exercise in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

11. List five qualities and behaviors that should be evident in others before interpersonal trust can be built. (17)

17. Assist the client in developing a set of character traits to be sought in others (e.g., honesty, sensitivity, kindness) that qualify them as trustworthy.

12. Increase the frequency of telling the truth rather than saying only what the client thinks the other person wants to hear. (18, 19)

18. Teach the client that the behavior of telling other people what we think they want to hear rather than speaking the truth is based on fear of rejection, which was learned in the alcoholic home; use modeling, role-playing, and behavior rehearsal to teach the client more honest communication skills.

19. Assign the client to keep a journal of incidents in which he/she told the truth rather than saying only what others wanted to hear.

13. List the steps to effectively and independently solving problems. (20)

20. Teach the client problem-solving skills (e.g., identify the problem, brainstorm alternate solutions, examine the advantages and disadvantages of each option, select an option, implement a course of action, and evaluate the result); role-play solving a current problem in his/her life (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

14. Acknowledge the resistance to sharing personal problems; share at least one problem in each therapy session. (5, 16, 21, 22)

5. Educate the client about the ACOA rules of "don't talk, don't trust, don't feel"; explain how these rules make healthy relationships impossible.

16. Probe how the client's family responded to expressions of feelings, wishes, and wants and why it became dangerous for the client to share feelings with others.

21. Educate the client about healthy interpersonal relationships based on openness, respect, and honesty; explain the necessity of sharing feelings to build trust and mutual understanding (or assign the client to complete the honesty exercise in *The Alcoholism & Drug*

	Abuse Patient Workbook by Perkinson).
	22. Explore the client's pattern of resistance to sharing personal problems and preferring, instead, to focus on helping others with their problems.
15. Verbalize an understanding of how ACOA traits contribute to choosing partners and friends that have problems and need help. (10, 23)	10. Assist the client in understanding how his/her early childhood experiences led to fears of abandonment, rejection, neglect, and to an assumption of the caretaker role, which is detrimental to intimate relationships.
	23. Help the client to understand that his/her strong need to help others is based on low self-esteem and the need for acceptance, which was learned in the alcoholic family-of-origin; relate this caretaking behavior to choosing friends and partners who are chemically dependent and/or psychologically disturbed.
16. Initiate the encouragement of others in recovery, to help reestablish a feeling of self-worth. (24, 25)	24. Teach the client that active involvement in a recovery group can aid in building trust in others and confidence in himself/herself.
	25. Assist the client in developing an aftercare plan that is centered on regular attendance at Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings.
17. List reasons why regular attendance at recovery group meetings is necessary to arrest ACOA traits and addiction. (26)	26. Assist the client in listing reasons why 12-step recovery group attendance is helpful to overcome ACOA traits.
18. Discuss fears that are related to attending recovery group meetings, and develop specific written plans to deal with each fear. (27)	27. Probe the relationship between ACOA traits and the fear of attending recovery group meetings; assist the client in developing coping strategies to cope with the fear (e.g., give self

positive messages regarding self-worth, use relaxation techniques to reduce tension, use meditation to induce calm and support from a higher power).

19. Verbalize how a recovery group can become the healthy family that one never had. (24, 28, 29)

24. Teach the client that active involvement in a recovery group can aid in building trust in others and confidence in himself/herself.

28. Discuss how the home group of AA/NA can function as the healthy family the client never had; help him/her realize why he/she needs such a family to recover.

29. Educate the client about the family atmosphere in a home AA/NA recovery group, and how helping others can aid in recovery and reestablish a feeling of worth.

20. List five ways in which belief in, and interaction with, a higher power can reduce fear and aid in recovery. (30, 31)

30. Teach the client how faith in a higher power can aid in recovery and arrest ACOA traits and addiction (or assign the client to complete the Step Two exercise in *The Alcoholism & Drug Abuse Treatment Workbook* by Perkinson).

31. Assign the client to read the Alcoholics Anonymous *Big Book* on the topic of spirituality and the role of a higher power; process the material in an individual or group therapy session.

21. Verbalize the feeling of serenity that results from turning out-of-control problems over to a higher power. (32)

32. Review problematic circumstances in the client's life that could be turned over to a higher power to increase serenity.

22. Practice assertiveness skills and share how these skills were used in interpersonal conflict. (33, 34)

33. Use modeling, behavior rehearsal, and role-playing to teach the client healthy, assertive skills (or assign "Making Your Own Decisions" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by

	Jongsma); apply these skills to several current problem situations, and then ask the client to journal his/her assertiveness experiences.
	34. Teach the client the assertive formula of "I feel ____ when you ____. I would prefer it if ____"; role-play several applications in his/her life and then assign him/her to use this formula three times per day.
23. Share the personal experiences of each day with one person that day. (35, 36)	35. Teach the client the *share check* method of building trust, in which the degree of shared information is related to a proven level of trustworthiness; use behavior rehearsal of several situations in which the client shares feelings.
	36. Review and reinforce instances when the client has shared honestly and openly with a trustworthy person.
24. Cooperate with a physician's evaluation for psychopharmacological intervention. (37)	37. Refer the client to a physician to evaluate whether psychopharmacological interventions are warranted.
25. Take medications as prescribed, and report on their effectiveness and side effects. (38, 39)	38. Medical staff administers medications to the client as prescribed.
	39. Monitor the client's medications for effectiveness and side effects.
26. Complete a re-administration of objective tests of traits associated with being an adult child of an alcoholic as a means of assessing treatment outcome. (40)	40. Assess the outcome of treatment by re-administering to the client objective tests of ACOA traits; evaluate the results and provide feedback to the client.
27. Complete a survey to assess the degree of satisfaction with treatment. (41)	41. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	311	Depressive Disorder NOS
	300.00	Anxiety Disorder NOS
	309.81	Posttraumatic Stress Disorder
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	301.9	Personality Disorder NOS

ANGER

BEHAVIORAL DEFINITIONS

1. Has a history of explosive, aggressive outbursts, particularly when intoxicated, which led to assaultive acts or destruction of property.
2. Abuses substances to cope with angry feelings and to relinquish responsibility for aggression.
3. Passively withholds feelings then explodes in a violent rage.
4. Angry overreaction to perceived disapproval, rejection, or criticism.
5. Demonstrates a tendency to blame others rather than accept responsibility for own problems.
6. Persistent pattern of challenging or disrespecting authority figures.
7. Body language of tense muscles (e.g., clenched fists or jaw, glaring looks, or refusal to make eye contact).
8. Views aggression as a means of achieving needed power and control.
9. Uses verbally abusive language.

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LONG-TERM GOALS

1. Maintain a program of recovery that is free of addiction and violent behavior.
2. Decrease the frequency of occurrence of angry thoughts, feelings, and behaviors.
3. Implement cognitive behavioral skills necessary to solve problems in a less aggressive and more constructive manner.

4. Stop blaming others for problems, and accept responsibility for own feelings, thoughts, and behaviors.
5. Learn and implement anger management skills to reduce the level of stress and the irritability that accompanies it.
6. Learn the assertive skills that are necessary to reduce angry feelings, and solve problems in a less aggressive and more constructive manner.

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SHORT-TERM OBJECTIVES

1. Identify situations, thoughts, feelings that trigger anger, angry verbal and/or behavioral actions and the targets of those actions. (1)
2. Complete psychological testing or objective questionnaires for assessing anger expression. (2)
3. Verbalize an understanding of how angry thoughts and feelings can lead to increased risk of addiction. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts, feelings, and actions that have characterized his/her anger responses.
2. Administer to the client psychological instruments designed to objectively assess anger expression (e.g., Anger, Irritability, and Assault Questionnaire [AIAQ], Buss-Durkee Hostility Inventory [BDHI], State-Trait Anger Expression Inventory [STAXI]); give the client feedback regarding the results of the assessment.
3. Educate the client about his/her tendency to engage in addictive behavior as a means of relieving uncomfortable feelings; develop a list of several instances of occurrence.

	4. Teach the client about high-risk situations of strong negative emotions, social pressure, interpersonal conflict, strong positive emotions, and testing personal control; discuss how anger, as a strong negative emotion, places him/her at a high risk for addiction.
4. Cooperate with a physician's evaluation regarding whether psychopharmacological intervention is warranted. (5)	5. Refer the client to a physician for an evaluation as to whether psychopharmacological interventions are warranted.
5. Take medications as prescribed, and report as to the effectiveness as well as side effects. (6, 7)	6. Medical staff administers medications to the client as prescribed.
	7. Monitor the client's medications for effectiveness and side effects.
6. Keep a daily journal of persons, situations, and other triggers of anger; record thoughts, feelings, and actions taken. (8)	8. Assign the client to keep an ongoing log of situations that precipitate angry feelings, noting the thoughts, feelings, intensity, and duration of anger (rate on a scale), and any actions taken in anger (or assign "Anger Journal" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma; "Is My Anger Due to Feeling Threatened?" or "Is My Anger Due to Unmet Expectations?" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz); review the log to help the client understand the causes and extent of his/her anger.
7. Verbalize increased awareness of anger expression patterns, their causes, and their consequences. (9, 10, 11)	9. Assist the client in reconceptualizing anger as involving different components (cognitive, physiological, affective, and behavioral) that go through predictable phases (e.g., demanding expectations not being met leading

to increased arousal and anger leading to acting out) that can be challenged and changed.

10. Assist the client in generating a list of anger triggers; process the list toward helping the client understand how cognitive, physiological, and affective factors interplay to produce anger.

11. Ask the client to list ways anger has negatively impacted his/her daily life; process this list.

8. Agree to learn new alternative ways to recognize and manage anger. (12)

12. Ask the client to agree to learn new ways to recognize and manage anger.

9. Learn calming strategies as part of managing reactions to frustration. (13)

13. Teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming self-talk or imagery) as part of a tailored strategy for responding appropriately to angry feelings when they occur.

10. Identify, challenge, and replace anger inducing self-talk with self-talk that facilitates a less angry reaction. (14, 15)

14. Explore the client's self-talk that mediates his/her angry feelings and actions (e.g., demanding expectations reflected in should, must, or have to statements); identify and challenge biases; assist him/her in generating appraisals and self-talk that corrects for the biases and facilitate a more flexible and temperate response to frustration.

15. Assign the client a homework exercise in which he/she identifies angry self-talk and generates alternatives that help moderate angry reactions; review; reinforce success, providing corrective feedback toward improvement (or assign the client to complete "Correcting Distorting Thinking"

from the *Addiction Treatment Homework Planner*, 4th edition, by Finley and Lenz).

11. Learn and implement thought stopping to manage intrusive unwanted thoughts. (16)

16. Teach the client the "thought-stopping" technique as part of a tailored strategy for managing angry thoughts and feelings (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); review implementation; reinforce success, providing corrective feedback toward improvement.

12. Learn to verbalize feelings of anger in a controlled, assertive way. (17)

17. Use instruction, modeling and/or role-playing to teach the client assertive communication; if indicated, refer him/her to an assertiveness training class/group for further instruction.

13. Learn and implement problem solving and/or conflict resolution skills to manage interpersonal problems. (18, 19)

18. Teach the client conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise); use modeling, role-playing, and behavior rehearsal to work through several current conflicts.

19. Conduct conjoint sessions, if needed, to help learn assertion, problem-solving, and/or conflict resolution skills.

14. Combine learned anger management skills into a new approach to handling frustration. (20)

20. Assist the client in adopting a client-tailored strategy for managing anger that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to their needs.

15. Practice using new anger management skills in session with the therapist and during homework exercises. (21, 22)

21. Select situations in which the client will be increasingly challenged to apply his/her new strategies for managing anger.

16. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (23)

17. Identify social supports that will help facilitate the implementation of anger management skills. (24)

18. Learn and implement relapse prevention strategies. (25, 26, 27, 28, 29)

22. Use any of several techniques, including imagery, behavioral rehearsal, modeling, role-playing, or *in vivo* exposure/behavioral experiments to help the client consolidate the use of his/her new anger management skills.

23. Monitor angry outbursts toward the goal of decreasing their frequency, intensity, and duration through the use of the client's new anger management skills (or assign "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); review data; reinforce success; provide corrective feedback toward improvement.

24. Encourage the client to discuss their anger management goals with trusted persons who are likely to support his/her change.

25. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible angry outburst and relapse with the choice to return routinely to their old pattern of anger.

26. Identify and rehearse with the client the management of future situations or circumstances in which lapses back into inappropriate anger could occur.

27. Instruct the client to routinely use new anger management strategies learned in therapy (e.g., calming, adaptive self-talk, assertion, and/or conflict resolution) to respond to frustrations.

28. Develop a "coping card" or other reminder on which new anger management skills and other

important information (e.g., "calm yourself, be flexible in your expectations of others, voice your opinion calmly, respect other's point of view") are recorded for the client's later use.

29. Schedule periodic "maintenance" sessions to help the client maintain therapeutic gains.

19. Read self-help material to increase understanding of the therapy and implementation of its practice. (30)

30. Assign the client to read material consistent with therapeutic goals; integrate points from the material at relevant points throughout therapy (e.g., *Overcoming Situational and General Anger*: *Client Manual* by Deffenbacher and McKay).

20. Verbalize an understanding of the relationship between the feelings of worthlessness and hurtfulness that were experienced in the family of origin and the current feelings of anger. (31, 32, 33)

31. Assign the client to list painful experiences of his/her life that have led to anger and resentment.

32. Probe the client's experience with his/her family of origin and help him/her to see how these experiences led to a tendency to see people and situations as dangerous and threatening.

33. Assist the client in identifying ways that key life figures (e.g., father, mother, teachers) have expressed angry feelings and how these experiences have positively or negatively influenced the way he/she handles anger.

21. Verbalize an understanding of how anger has been reinforced as a coping mechanism for stress. (34)

34. Teach the client how anger blocks the awareness of pain, discharges uncomfortable feelings, erases guilt, and places the blame for problems on others.

22. Verbalize regret and remorse for the harmful consequences of anger. (35)

35. Use modeling and role reversal to make the client more aware of how his/her aggressive behavior has had negative consequences on others (e.g., spouse, children) who

	have been the targets of or witness to violence.
23. Verbalize an understanding of the need for and process of forgiving others so as to reduce anger. (36)	36. Assist the client in identifying whom he/she needs to forgive, and educate him/her as to the long-term process that is involved in forgiveness versus a magical single event; recommend reading books on forgiveness (e.g., *Forgive and Forget* by Smedes); review the client's progress, reinforce success, and assess its impact on anger reduction.
24. Verbalize an understanding of the concept of a higher power and the benefits of acceptance of such a concept. (37)	37. Teach the client about the 12-step recovery program concept of a higher power, and how to turn over perpetrators of pain to his/her higher power for judgment.
25. Implement regular physical exercise to reduce tension. (38)	38. Teach the client the benefits of regular physical exercise; assign a program of implementation.
26. Attend 12-step recovery group meetings regularly, and share feelings with others there. (39)	39. Teach the client the importance of actively attending 12-step recovery meetings, getting a sponsor, reinforcing people around him/her, and sharing feelings.
27. Complete a re-administration of objective tests of anger expression as a means of assessing treatment outcome. (40)	40. Assess the outcome of treatment by re-administering to the client objective tests of anger expression (e.g., Anger Irritability and Assault Questionnaire (AIAQ), Buss-Durkee Hostility Inventory (BDHI), State-Trait Anger Expression Inventory (STAXI); evaluate the results and provide feedback to the client.
28. Complete a survey to assess the degree of satisfaction with treatment. (41)	41. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	312.8	Conduct Disorder
	313.81	Oppositional Defiant Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	312.34	Intermittent Explosive Disorder
	312.30	Impulse-Control Disorder NOS
	309.4	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
	_____	_____
	_____	_____
Axis II:	301.0	Paranoid Personality Disorder
	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS
	301.81	Narcissistic Personality Disorder
	_____	_____
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ANTISOCIAL BEHAVIOR

BEHAVIORAL DEFINITIONS

1. Has a history of breaking the rules or the law (often under the influence of drugs or alcohol) to get his/her own way.
2. Exhibits a pervasive pattern of disregard for and violation of the rights of others.
3. Consistently blames other people for his/her own problems and behaviors.
4. Uses aggressive behavior to manipulate, intimidate, or control others.
5. Demonstrates a chronic pattern of dishonesty.
6. Lives a hedonistic, self-centered lifestyle, with little regard for the needs and welfare of others.
7. Verbalizes a lack of empathy for the feelings of others, even if they are friends or family.
8. Presents a pattern of criminal activity and addiction, going back to one's adolescent years.
9. Engages in dangerous, thrill-seeking behavior, without regard for the safety of self or others.
10. Makes decisions impulsively, without giving thought to the consequences for others.

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LONG-TERM GOALS

1. Develop a program of recovery that is free from addiction and the negative influences of antisocial behavior.
2. Learn the importance of helping others in recovery.
3. Learn how antisocial behavior and addiction is self-defeating.
4. Understand criminal thinking and develop self-talk that respects the welfare and rights of others.
5. Understand the importance of a program of recovery that demands rigorous honesty.
6. Take responsibility for one's own behavior.

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SHORT-TERM OBJECTIVES

1. Verbalize an acceptance of powerlessness and unmanageability over antisocial behavior and addiction. (1, 2)

2. Complete psychological testing or objective questionnaires for assessing antisocial behavior. (3)

THERAPEUTIC INTERVENTIONS

1. Help the client to understand the self-defeating nature of antisocial behavior and addiction (or assign the Step One exercise in *The Alcoholism & Drug Abuse Treatment Workbook* by Perkinson).

2. Help the client to see the relationship between antisocial behavior and addiction.

3. Administer to the client psychological instruments designed to objectively assess antisocial behavior, impulsivity, and/or aggression rating instruments (e.g., Psychopathy Checklist Revised [PCL-R], Aggressive Acts Questionnaire [AAQ], Barratt Impulsiveness

	Scale-11 [BIS-11]); give the client feedback regarding the results of the assessment.
3. State how antisocial behavior and addiction are associated with irrational thinking (AA's "insanity"). (4)	4. Help the client to understand how doing the same things over and over but expecting different results is irrational—what AA calls "insane."
4. Consistently follow all rules. (5)	5. Assign appropriate consequences when the client fails to follow rules or expectations.
5. Identify and verbalize the negative consequences that failure to comply with the rules/limits has had on self and others. (6, 7, 8)	6. Review with the client several examples where his/her rule and/or limit breaking led to negative consequences to self and others.
	7. Use role reversal techniques to sensitize the client to his/her lack of empathy for others by revisiting the consequences of his/her behavior on others (or assign "How I Have Hurt Others" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
	8. Teach the client that many negative consequences are preceded by decisions that are based on criminal thinking; ask the client to list five times when antisocial behavior led to negative consequences and list the many decisions that were made along the way.
6. List the ways dishonesty is self-defeating. (9)	9. Assist the client in understanding why dishonesty results in more lies, loss of trust from others, and, ultimately, rejection.
7. List the reasons why criminal activity leads to a negative self-image. (10)	10. Help the client understand why criminal activity leads to feelings of low self-esteem (e.g., loss of respect from others, broken relationships, legal problems, lack of achievement).

8. Verbalize how criminal thinking is used to avoid responsibility and to blame others. (11)

9. Decrease the frequency of statements blaming others or circumstances while increasing the frequency of statements accepting responsibility for one's own behavior, thoughts, and feelings. (12, 13, 14)

10. Develop a list of prosocial behaviors and practice one of these behaviors each day. (15)

11. Write a list of typical criminal thoughts; then replace each thought with one that is respectful of self and others. (16, 17)

12. List five ways AA/NA meetings and a higher power can assist in overcoming antisocial behavior and addiction. (18)

11. Teach the client how criminal thinking (e.g., super-optimism, little empathy for others, power orientation, sense of entitlement, self-centeredness) avoids personal responsibility and leads to blaming others.

12. Help the client to understand how blaming others results in a failure to learn from one's mistakes, and therefore making the same mistakes over again.

13. Explore with the client the reasons for blaming others for one's own problems and behaviors, and how he/she may have learned this behavior in a punishing family environment.

14. Confront the client's projection of blame for his/her behavior, feelings, and thoughts; reinforce his/her acceptance of personal responsibility.

15. Teach the client the difference between antisocial and prosocial behaviors, then help him/her develop a list of prosocial behaviors (e.g., helping others) to practice each day.

16. Confront the client's antisocial beliefs about his/her lack of respect for the rights and feelings of others, and model thoughtful attitudes and beliefs about the welfare of others.

17. Assist the client in identifying his/her typical antisocial thoughts; list an alternate, respectful, and trusting empathic thought.

18. Discuss with the client the various ways recovery groups and a belief in a higher power can assist him/her in recovery (e.g., provide

emotional support, provide social relationships, relieve anxiety, reinforce self-worth, provide guidance); or assign the Step Three exercise in *The Alcoholism & Drug Abuse Treatment Workbook* by Perkinson.

13. Receive feedback/redirection from staff/therapist without making negative gestures or remarks. (19)
14. Develop a written plan to address all pending legal problems in a constructive manner. (20)
15. Encourage at least one person in recovery each day. (21, 22)
16. Articulate the antisocial and addiction behaviors that have resulted in pain and disappointment to others and, therefore, a loss of their trust. (23, 24, 25)
17. Verbalize a desire to keep commitments to others, and list ways to prove oneself to be responsible, reliable, loyal, and faithful. (26)

19. Confront the client when he/she breaks the rules, blames others, or makes excuses.
20. Assist the client in addressing each legal problem honestly, taking responsibility for his/her behavior.
21. Teach the client why it is essential to attend recovery groups and to learn how to help others.
22. Using modeling, role-playing, and behavior rehearsal, practice with the client how he/she can encourage others in recovery.
23. Assist the client in developing a list of reasons why the trust of others is important as a basis for any relationship.
24. Encourage the client to be honest in acknowledging how he/she has hurt others (or assign "How I Have Hurt Others" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
25. Confront any denial of responsibility for irresponsible, self-centered, and impulsive behaviors (or assign "Letter of Apology" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
26. Discuss with the client the importance of keeping commitments and promises to others and ways to prove himself/herself as trustworthy in relationships.

18. Write an aftercare plan that includes a sponsor, AA meetings, and counseling. (27, 28)

19. Family members develop an aftercare plan that focuses on what they are expected to do to help the client recover. (29, 30, 31, 32)

20. Complete a re-administration of objective tests of antisocial behavior, impulsivity, and aggression as a means of assessing treatment outcome. (33)

27. Introduce the client to his/her AA/NA sponsor or encourage him/her to ask a stable recovery person to be a sponsor; teach him/her the many ways a sponsor can be used in recovery.

28. Help the client develop an aftercare program that specifically outlines what AA meetings will be attended, the psychotherapist he/she will be working with, and how a daily inventory will be taken (or assign "Taking Daily Inventory" in the *Addiction Treatment Homework Planner,* 4th ed. by Finley and Lenz).

29. Teach the family members about criminal thinking and show them how to help the client correct his/her inaccurate thoughts.

30. Teach the family the need to overcome their denial of making excuses for reinforcing or being intimidated by the client's antisocial behavior.

31. Use behavior rehearsal, modeling, and role-playing to teach the family members conflict resolution skills.

32. Assist each family member in identifying and listing how to encourage the client to recover from antisocial behavior and addiction.

33. Assess the outcome of treatment by re-administering to the client objective tests of antisocial behavior, impulsivity, and aggression (e.g., Psychopathy Checklist Revised [PCL-R], Aggressive Acts Questionnaire [AAQ], Barratt Impulsiveness Scale-11 [BIS-11]); evaluate the results and provide feedback to the client.

21. Complete a survey to assess the degree of satisfaction with treatment. (34)

34. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	312.8	Conduct Disorder
	313.81	Oppositional Defiant Disorder
	309.3	Adjustment Disorder with Disturbance of Conduct
	312.34	Intermittent Explosive Disorder
	V71.01	Adult Antisocial Behavior
	V71.02	Child or Adolescent Antisocial Behavior
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
	_____	_____

ANXIETY

BEHAVIORAL DEFINITIONS

1. Demonstrates excessive fear and worry regarding several life circumstances, which has no factual or logical basis.
2. Constantly worries about family, job, social interactions, and/or health.
3. Has a tendency to blame self for the slightest imperfection or mistake.
4. Expresses a fear of saying or doing something foolish in a social situation due to a lack of confidence in social skills.
5. Reports symptoms of autonomic hyperactivity (e.g., cardiac palpitations, shortness of breath, sweaty palms, dry mouth, trouble swallowing, nausea, diarrhea).
6. Demonstrates symptoms of motor tension (e.g., restlessness, tiredness, shakiness, muscle tension).
7. Abuses substances in an attempt to control anxiety symptoms.
8. Reports symptoms of hypervigilance (e.g., feeling constantly on edge, difficulty concentrating, sleep problems, irritability).

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LONG-TERM GOALS

1. Maintain a program of recovery, free from addiction and excessive anxiety.
2. End addiction as a means of escaping anxiety and practice constructive coping behaviors.
3. Learn to relax and think accurately and logically about events.
4. Stabilize anxiety level while increasing ability to function on a daily basis.
5. Learn coping techniques to decrease the effects of anxiety.
6. Reduce overall stress levels, reducing excessive worry and muscle tension.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the history of anxiety symptoms. (1, 2)	1. Assess the client's frequency, intensity, duration, and history of panic symptoms, fear, and avoidance (e.g., *The Anxiety Disorders Interview Schedule for the DSM-IV* by DiNardo, Brown, and Barlow). 2. Utilize a graphic display, such as a timeline, to help the client identify the pattern of anxiety symptoms that he/she has experienced (e.g., when they started, how they have varied in intensity or type over time); or assign "My Anxiety Profile" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz.
2. Acknowledge the powerlessness and unmanageability caused by excessive anxiety and addiction. (3, 4)	3. Help the client to see how anxiety and powerlessness over addiction has made his/her life unmanageable.

	4. Teach the client about the relationship between anxiety and addiction (e.g., how the substance was used to treat the anxious symptoms, why more substance use became necessary); or assign "Coping with Stress" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz.
3. Complete psychological testing or objective questionnaires for assessing client's level of anxiety. (5)	5. Administer an objective anxiety assessment instrument to the client (e.g., Beck Anxiety Inventory [BAI], Hamilton Anxiety Rating Scale [HARS], State-Trait Anxiety Inventory [STAI]); evaluate the results and give feedback to him/her.
4. Cooperate with a medication evaluation. (6)	6. Refer the client to a physician for an evaluation as to the need for psychotropic medications.
5. Report a decrease in anxiety symptoms through regular use of psychotropic medications. (7, 8)	7. Educate the client about the use and expected benefits of the medication.
	8. Monitor the client's medication compliance and effectiveness; reinforce consistent use of the medication.
6. Report the side effects and effectiveness of the medications to the appropriate professional. (9)	9. Review the effects of the medications with the client and the medical staff to identify possible side effects or confounding influence of polypharmacy.
7. Verbalize an understanding of the cognitive, physiological, and behavioral components of anxiety and its treatment. (10, 11, 12)	10. Discuss how generalized anxiety typically involves excessive worry about unrealistic threats, various bodily expressions of tension, overarousal, and hypervigilance, and avoidance of what is threatening that interact to maintain the problem (or assign "Analyze the Probability of a Feared Event" in the *Adult Psychotherapy Homework*

Planner, 2nd ed. by Jongsma and see *Mastery of Your Anxiety and Panic—Therapist Guide*, 4th ed. by Craske and Barlow).

11. Discuss how treatment targets worry, anxiety symptoms, and avoidance to help the client manage worry effectively, reduce overarousal, and eliminate unnecessary avoidance.

12. Assign the client to read psychoeducational sections of books or treatment manuals on worry and generalized anxiety (e.g., *Mastery of Your Anxiety and Panic—Workbook*, 4th ed. by Barlow, and Craske).

8. Learn and implement calming skills to reduce overall anxiety and manage anxiety symptoms. (13, 14, 15, 16)

13. Teach the client relaxation skills (e.g., progressive muscle, guided imagery, slow diaphragmatic breathing) and how to discriminate better between relaxation and tension; teach the client how to apply these skills to his/her daily life (e.g., *Progressive Relaxation Training* by Bernstein and Borkovec; *Treating GAD* by Rygh and Sanderson).

14. Assign the client homework each session in which he/she practices relaxation exercises daily; review and reinforce success while providing corrective feedback toward improvement.

15. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *Progressive Relaxation Training* by Bernstein and Borkovec; *Mastery of Your Anxiety and Panic—Workbook*, 4th ed. by Barlow and Craske).

9. Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk. (17, 18, 19, 20)

16. Use biofeedback techniques to facilitate the client's success at learning calming skills.
17. Explore the client's schema and self-talk that mediate his/her fear response, challenge the biases; assist him/her in replacing the distorted messages with reality-based alternatives and positive self-talk that will increase his/her self-confidence in coping with irrational fears.
18. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives (or assign "Negative Thoughts Trigger Negative Feelings" or "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); review and reinforce success, providing corrective feedback toward improvement.
19. Teach the client to implement a thought-stopping technique (thinking of a stop sign and then a pleasant scene) for worries that have been addressed but persist (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); monitor and encourage the client's use of the technique in daily life between sessions.
20. Assign the client to read about cognitive restructuring of worry in relevant books or treatment manuals (e.g., *Mastery of Your Anxiety and Panic—Workbook*, 4th ed. by Barlow and Craske).

10. Undergo gradual repeated imaginal exposure to the feared negative consequences predicted by irrational worries and develop reality-based predictions. (21, 22, 23, 24, 25)

21. Assign the client to read about "worry exposure" in books or treatment manuals on the treatment of worry and generalized anxiety (e.g., *Mastery of Your Anxiety and Panic—Workbook*, 4th ed. by Barlow and Craske).

22. Direct and assist the client in constructing a hierarchy of two to three spheres of worry for use in exposure (e.g., worry about harm to others, financial difficulties, relationship problems).

23. Select initial exposures that have a high likelihood of being a success experience for the client; develop a plan for managing the negative affect engendered by exposure; mentally rehearse the procedure.

24. Assign the client a homework exercise in which he/she does worry exposures and records responses (see *Mastery of Your Anxiety and Panic—Workbook*, 4th ed. by Barlow and Craske, or *Generalized Anxiety Disorder* by Brown, O'Leary, and Barlow*)*; review, reinforce success, and provide corrective feedback toward improvement.

25. Ask the client to vividly imagine worst-case consequences of worries, holding them in mind until anxiety associated with them weakens (up to 30 minutes); generate reality-based alternatives to that worst case and process them (see *Mastery of Your Anxiety and Panic—Therapist Guide*, 4th ed. by Craske and Barlow).

11. Learn and implement problem-solving strategies for realistically addressing worries. (26, 27)

26. Teach problem-solving strategies involving specifically defining a problem, generating options for addressing it, evaluating options,

implementing a plan, and re-evaluating and refining the plan.

27. Assign the client a homework exercise in which he/she problem-solves a current problem (see *Mastery of Your Anxiety and Panic—Workbook*, 4th ed. by Barlow and Craske or *Generalized Anxiety Disorder* by Brown, O'Leary, and Barlow); review, reinforce success, and provide corrective feedback toward improvement (or assign "Applying Problem-Solving to Interpersonal Conflict" or "Problem Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

12. Learn and implement relapse prevention strategies for managing possible future anxiety symptoms. (28, 29, 30)

28. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of worry, anxiety symptoms, or urges to avoid and relapse with the decision to continue the fearful and avoidant patterns.

29. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

30. Instruct the client to routinely use relaxation, cognitive restructuring, exposure, and problem-solving exposures as needed to address emergent worries, building them into his/her life as much as possible.

13. Identify the fears that were learned in the family of origin, and relate these fears to current anxiety levels. (31, 32, 33)

31. Probe the client's family-of-origin experiences for fear-producing situations; help him/her relate these past events to current anxious thoughts, feelings, and behaviors.

32. Encourage and support the client's verbal expression and clarification of his/her feelings that are associated with past rejection experiences, harsh criticism, abandonment, or trauma.
33. Assign the client to read books on resolving painful early family experiences (e.g., *Healing the Shame That Binds You* by Bradshaw or *Facing Shame* by Fossum and Mason); process key concepts learned from the reading.

14. Write a specific plan to follow when anxious and subsequently craving substance use. (34, 35, 36, 37)

34. Facilitate the client's use of logic and reasoning to challenge the irrational thoughts associated with unreasonable worries and to replace those thoughts with reasonable ones.
35. Assist the client in developing a list of 10 positive statements to read to himself/herself several times per day, particularly with feeling anxious.
36. Using a 12-step program's Step Three exercise, show the client how to turn over problems, worries, and anxieties to a higher power and to trust that the higher power is going to help him/her resolve the situation.
37. Help the client develop an alternative constructive plan of action (e.g., relaxation exercises, physical exercise, calling a sponsor, going to a meeting, calling the counselor, talking to someone) when feeling anxious and craving substance use.

15. Develop a leisure program that will increase the frequency of engaging in pleasurable activities and will affirm the client's sense of self. (38)

38. Help the client develop a plan of engaging in pleasurable leisure activities (e.g., clubs, hobbies, church, sporting activities, social activities, games) that increase

enjoyment of life and affirm himself/herself.

16. Write an autobiography, detailing those behaviors in the past that are related to current anxiety or guilt, and the subsequent abuse of substances as a means of escape. (31, 39)

31. Probe the client's family-of-origin experiences for fear-producing situations; help him/her relate these past events to current anxious thoughts, feelings, and behaviors.

39. Using a 12-step program's Step Four exercise, have the client write an autobiography detailing the exact nature of his/her mistakes; teach the client how to begin to forgive himself/herself and others (or assign the client to complete the Step Four exercise from *The Alcoholism & Drug Abuse Patient Workbook*, by Perkinson).

17. Develop a program of recovery that includes regularly helping others at recovery group meetings. (40)

40. Help the client develop a structured program of recovery that includes regularly helping others at 12-step program recovery groups.

18. Family members verbalize an understanding of anxiety and addiction, and discuss the ways they and the client can facilitate the recovery process. (41, 42, 43)

41. Assist each family member in developing a list of three things that he or she can do to assist the client in recovery; hold a family session to facilitate communication of the actions on the list.

42. Provide the family members with information about anxiety disorders and the tools that are used to assist the client in recovery.

43. Discuss with the family the connection between anxiety and addiction.

19. Complete a re-administration of objective tests of anxiety as a means of assessing treatment outcomes. (44)

44. Assess the outcome of treatment by re-administering to the client objective tests of anxiety; evaluate the results and provide feedback to the client.

20. Complete a survey to assess the degree of satisfaction with treatment. (45)

45. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.21	Separation Anxiety Disorder
	291.89	Alcohol-Induced Anxiety Disorder
	300.01	Panic Disorder without Agoraphobia
	300.21	Panic Disorder with Agoraphobia
	300.23	Social Phobia
	300.3	Obsessive-Compulsive Disorder
	308.3	Acute Stress Disorder
	300.02	Generalized Anxiety Disorder
	_____	_____
	_____	_____
Axis II:	301.50	Histrionic Personality Disorder
	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	_____	_____
	_____	_____

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) – ADOLESCENT

BEHAVIORAL DEFINITIONS

1. Demonstrates a pattern of restlessness and hyperactivity leading to attention deficits or learning disability.
2. Is unable to focus attention long enough to learn appropriately.
3. Often fidgets with hands or squirms in seat.
4. Often leaves seat in situations where sitting is required.
5. Moves about excessively in situations in which it is inappropriate.
6. Demonstrates inability to exclude extraneous stimulation.
7. Blurts out answers before questions have been completed.
8. Has difficulty waiting in lines or waiting his/her turn.
9. Often intrudes or talks excessively.
10. Acts too quickly on feelings without thought or deliberation.
11. ADHD traits increase vulnerability to addictive behaviors.

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LONG-TERM GOALS

1. Maintain a program of recovery from addiction, and reduce the negative effects of Attention-Deficit/Hyperactivity Disorder on learning, social interaction, and self-esteem.
2. Develop the coping skills necessary to improve Attention-Deficit/Hyperactivity Disorder and eliminate addiction.
3. Understand the relationship between Attention-Deficit/Hyperactivity Disorder symptoms and addiction.
4. Develop the skills necessary to bring Attention-Deficit/Hyperactivity Disorder symptoms under control, so normal learning can take place.
5. Decrease impulsivity by learning how to stop, think, and plan before acting.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Complete psychological testing or objective questionnaires for assessing ADHD and substance abuse. (1)	1. Administer to the client psychological instruments designed to objectively assess ADHD (e.g., Conners' ADHD Rating Scales [CARS], Substance Abuse Subtle Screening Inventory-3 [SASSI-3]); give the client feedback regarding the results of the assessment.
2. Complete psychological testing to rule out emotional factors or learning disabilities as the basis for maladaptive behavior. (2, 3)	2. Arrange for psychological testing to rule out emotional factors or learning disabilities as the basis for the client's maladaptive behavior. 3. Give feedback to the client and his/her family regarding psychological testing results.
3. Identify the symptoms of ADHD and their impact on daily living. (4, 5)	4. Teach the client how to monitor ADHD symptoms and rate the severity of symptoms on a scale of 1 to 100 each day.

	5. Explore the client's pattern of ADHD symptoms and their impact on his/her daily living.
4. Verbalize the powerlessness and unmanageability that resulted from treating ADHD symptoms with addiction. (6)	6. Using a 12-step recovery program's Step One exercise, help the client to accept his/her powerlessness and unmanageability over ADHD symptoms and addiction (or assign the client to complete the Step One exercise from *The Alcoholism & Drug Abuse Patient Workbook,* by Perkinson).
5. Verbalize the relationship between ADHD and addiction. (7)	7. Using a biopsychosocial approach, teach the client about the relationship between ADHD symptoms and the use of substances to control symptoms.
6. Implement a program of recovery structured so as to bring ADHD and addiction under control. (8)	8. Help the client to develop a program of recovery that includes the elements necessary to bring ADHD and addiction under control (e.g., medication, behavior modification, environmental controls, aftercare meetings, further therapy).
7. List five ways a higher power can be used to assist in recovery from ADHD and addiction. (9)	9. Teach the client about the AA concept of a higher power and how this power can assist him/her in recovery.
8. Implement remedial procedures for any learning disabilities that add to the client's frustration. (10)	10. Refer the client to an educational specialist to design remedial procedures for any learning disabilities that may be present in addition to ADHD.
9. Take prescribed medication as directed by the physician. (11, 12)	11. Arrange for a medication evaluation for the client.
	12. Monitor the client for psychotropic medication prescription compliance, side effects, and effectiveness; consult with the prescribing physician at regular intervals.

10. Parents and the client increase knowledge about ADHD symptoms. (13, 14, 15)

13. Educate the client's parents and siblings about the symptoms of ADHD.

14. Assign the parents readings to increase their knowledge about symptoms of ADHD (e.g., *Taking Charge of ADHD* by Barkley, *ADHD and Teens* by Alexander-Roberts, and *Teenagers with ADD* by Dendy-Zeigler).

15. Assign the client readings to increase his/her knowledge about ADHD and ways to manage symptoms (e.g., *Adolescents and ADD* by Quinn, and *ADHD—A Teenager's Guide* by Crist).

11. Parents develop and utilize an organized system to keep track of the client's school assignments, chores, and household responsibilities. (16, 17)

16. Assist the parents in developing and implementing an organizational system to increase the client's on-task behaviors and completion of school assignments, chores, or household responsibilities (e.g., using calendars, charts, notebooks, and class syllabi; or assign the client to complete the "Mastering Your Adult ADHD" exercise by Safren, Sprich, Perlman, and Otto).

17. Assist the parents in developing a routine schedule to increase the client's compliance with school, household, or work-related responsibilities.

12. Parents maintain communication with the school to increase the client's compliance with completion of school assignments. (18)

18. Encourage the parents and teachers to maintain regular communication about the client's academic, behavioral, emotional, and social progress.

13. Utilize effective study skills on a regular basis to improve academic performance. (19, 20)

19. Teach the client more effective study skills (e.g., clearing away distractions, studying in quiet places, scheduling breaks in studying).

14. Increase frequency of completion of school assignments, chores, and household responsibilities. (17, 21, 22)

15. Implement effective test-taking strategies on a consistent basis to improve academic performance. (23)

16. Delay instant gratification in favor of achieving meaningful long-term goals. (24, 25)

17. Assist the parents in developing a routine schedule to increase the client's compliance with school, household, or work-related responsibilities.

20. Assign the client to read *13 Steps to Better Grades* by Silverman to improve organizational and study skills.

21. Consult with the client's teachers to implement strategies to improve school performance (e.g., sitting in the front row during class, using a prearranged signal to redirect the client back to task, scheduling breaks from tasks, providing frequent feedback, calling on the client often, arranging for a listening buddy).

22. Encourage the parents and teachers to utilize a school contract and reward system to reinforce completion of the client's assignments (or employ the "Getting It Done" program in the *Adolescent Psychotherapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis).

23. Teach the client more effective test-taking strategies (e.g., reviewing material regularly, reading directions twice, rechecking work).

24. Teach the client mediational and self-control strategies (e.g., "stop, look, listen, and think") to delay the need for instant gratification and inhibit impulses to achieve more meaningful, long-term goals.

25. Assist the parents in increasing structure to help the client learn to

delay gratification for longer-term goals (e.g., completing homework or chores before playing basketball).

17. Implement Behavioral Parent Training in which the client and his/her parents comply with the implementation of a reward/punishment system, contingency contract, and/or token economy to promote positive change. (26, 27, 28, 29, 30)

26. Use a Parent Management Training approach beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to reduce the frequency of impulsive, disruptive, and negative attention-seeking behaviors and increase desired behavior (e.g., see *Parenting the Strong-willed Child* by Forehand and Long; *Living with Children* by Patterson).

27. Teach the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.

28. Teach the parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise), use of clear direct instruction, time out, and other loss-of-privilege practices for problem behavior.

29. Assign the parents home exercises in which they implement and record results of implementation

exercises (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.

30. Ask the parents to read parent training manuals (e.g., *Parenting Through Change* by Forgatch) or watch videotapes demonstrating the techniques being learned in session (see *Troubled Families—Problem Children* by Webster-Stratton).

18. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (31, 32, 33)

31. Use instruction, modeling, and role-playing to build the client's general social and/or communication skills.

32. Work with the parents and assign exercises that facilitate the client's use of social skills in various everyday situations.

33. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner) or assign the "Social Skills Exercise" in the *Adolescent Psychotherapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis.

19. Identify and implement effective problem-solving strategies. (34, 35)

34. Teach the client effective problem-solving skills (e.g., identifying the problem, brainstorming alternative solutions, selecting an option, implementing a course of action, and evaluating).

	35. Utilize role-playing and modeling to teach the client how to implement effective problem-solving techniques in his/her daily life (or assign the "Stop, Think, and Act" exercise in the *Adolescent Psychotherapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis).
20. Learn and implement constructive coping strategies to use when the negative emotions associated with failure are a trigger for addiction. (36, 37)	36. Review specific instances of failure to learn and the negative emotions associated with the experience; focus on how addictive behavior was used to escape from negative emotions.
	37. Role-play and model constructive alternative coping behaviors to use in failure-to-learn situations (e.g., cognitive focusing, deep breathing, make lists, reduce distractions, shorten learning sessions, repeat instructions verbally).
21. Report instances when relaxation techniques reduced tension and frustration while increasing focus in a learning situation. (38, 39, 40)	38. Using techniques like progressive relaxation, guided imagery, or biofeedback, teach the client how to relax completely; assign him/her to relax twice per day for 10 to 20 minutes per session.
	39. Encourage the client to implement relaxation skills as a coping and focusing mechanism when feeling tense and frustrated by a learning situation.
	40. Review the client's implementation of relaxation techniques; reinforce success and redirect for failure.
22. Develop and implement an exercise program that includes exercising at a training heart rate for at least 20 minutes at least three times per week. (41)	41. Help the client develop an exercise program; increase the exercise by 10 percent each week until the client is exercising at a training heart rate for at least 20 minutes, at least three times a week.

23. Develop an aftercare program that includes regular attendance at recovery group meetings, getting a sponsor, and continuing the therapy necessary to bring ADHD and addiction under control. (42)

24. Complete a re-administration of objective tests of ADHD and addiction as a means of assessing treatment outcome. (43)

25. Complete a survey to assess the degree of satisfaction with treatment. (44)

42. Help the client to develop an aftercare program that includes regular attendance at recovery group meetings, getting a sponsor, and continuing the therapy necessary to bring ADHD and addictive behavior under control.

43. Assess the outcome of treatment by re-administering to the client objective tests of ADHD; evaluate the results and provide feedback to the client.

44. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type
	314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
	314.9	Attention-Deficit/Hyperactivity Disorder NOS
	312.8	Conduct Disorder
	313.81	Oppositional-Defiant Disorder
	312.9	Disruptive Behavior Disorder NOS
	312.30	Impulse-Control Disorder NOS
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	_____	_____
	_____	_____

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) – ADULT

BEHAVIORAL DEFINITIONS

1. Demonstrates a pattern of restlessness and hyperactivity leading to attention deficits or learning disability.
2. Does not complete tasks or takes a longer than necessary amount of time to complete tasks.
3. Shows poor time-management skills.
4. Is easily overwhelmed with tasks that require attention to many details.
5. Shows poor planning and organizational skills.
6. Often loses or misplaces items.
7. Intrudes on conversations or talks excessively.
8. Acts too quickly on feelings without thought or deliberation.
9. ADHD traits increase vulnerability to addictive behaviors.

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LONG-TERM GOALS

1. Maintain a program of recovery from addiction and reduce the negative effects of Attention-Deficit/Hyperactivity Disorder on learning, social interaction, and self-esteem.
2. Develop the coping skills necessary to improve Attention-Deficit/Hyperactivity Disorder and eliminate addiction.

3. Understand the relationship between Attention-Deficit/Hyperactivity Disorder symptoms and addiction.
4. Develop the skills necessary to bring Attention-Deficit/Hyperactivity Disorder symptoms under control so normal learning can take place.
5. Decrease impulsivity by learning how to stop, think, and plan before acting.

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SHORT-TERM OBJECTIVES

1. Complete psychological testing or objective questionnaires for assessing ADHD and substance abuse. (1)
2. Complete psychological testing to rule out emotional factors or learning disabilities as the basis for maladaptive behavior. (2, 3)
3. Identify the symptoms of ADHD and their impact on daily living. (4, 5)

THERAPEUTIC INTERVENTIONS

1. Administer to the client psychological instruments designed to objectively assess ADHD (e.g., Conners' Adult ADHD Rating Scales [CAARS], Substance Abuse Subtle Screening Inventory-3 [SASSI-3]); give the client feedback regarding the results of the assessment; re-administer as needed to assess outcome.
2. Arrange for psychological testing to rule out emotional factors or learning disabilities as the basis for the client's maladaptive behavior.
3. Give feedback to the client and his/her family regarding psychological testing results.
4. Explore the client's pattern of ADHD symptoms and their impact on his/her daily functioning.
5. Teach the client how to monitor ADHD symptoms and assign monitoring tasks selectively for use in therapy.

4. Verbalize the powerlessness and unmanageability that resulted from treating ADHD symptoms with addiction. (6)

6. Using a 12-step recovery program's Step One exercise, help the client to accept his/her powerlessness and unmanageability over ADHD symptoms and addiction (or assign the client to complete the Step One exercise from *The Alcoholism & Drug Abuse Patient Workbook,* by Perkinson).

5. Verbalize the relationship between ADHD and addiction. (7)

7. Using a biopsychosocial approach, teach the client about the relationship between ADHD symptoms and the use of substances to control symptoms.

6. Implement a program of recovery structured so as to bring ADHD and addiction under control. (8)

8. Help the client to develop a program of recovery that includes the elements necessary to bring ADHD and addiction under control (e.g., medication, behavior modification, environmental controls, aftercare meetings, further therapy; or assign the client to complete the "Mastering Your Adult ADHD," exercise in *Mastery of Your Adult ADHD—Client Manual* by Safren, Spirch, Perlman, and Otto).

7. List five ways a higher power can be used to assist in recovery from ADHD and addiction. (9)

9. Teach the client about the AA concept of a higher power and how this power can assist him/her in recovery.

8. Implement remedial procedures for any learning disabilities that add to the client's frustration. (10)

10. Refer the client to an educational specialist to design remedial procedures for any learning disabilities that may be present in addition to ADHD.

9. Take prescribed medication as directed by the physician. (11, 12)

11. Arrange for a medication evaluation for the client.

12. Monitor the client for psychotropic medication prescription compliance, side effects, and effectiveness; consult with the

prescribing physician at regular intervals.

10. Increase knowledge about ADHD symptoms and their treatment. (13, 14, 15)

13. Educate the client about the signs and symptoms of ADHD and how they disrupt functioning through the influence of distractibility, poor planning and organization, maladaptive thinking, frustration, impulsivity, and possible procrastination (or assign "Symptoms and Fixes for ADD" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

14. Discuss a rationale for treatment that accordingly targets improvement in organizational and planning skills, management of distractibility, cognitive restructuring, and overcoming procrastination (see *Mastery of Your Adult ADHD-Therapist Manual* by Safren et al.).

15. Assign the client readings to increase their knowledge of ADHD and its treatment (e.g., *Mastery of Your Adult ADHD—Client Workbook* by Safren, Spirch, Perlman, and Otto).

11. Learn and implement organization and time management skills. (16, 17, 18, 19)

16. Teach the client organization and planning skills including the routine use of a calendar, and daily task list.

17. Develop with the client a procedure for classifying and managing mail and other papers as well as scheduled appointments.

18. Teach the client problem-solving skills as an approach to planning; for each plan, break it down into manageable time-limited steps to reduce the influence of distractibility (or assign "Getting

	Organized" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
	19. Assign homework asking the client to apply problem-solving skills to an everyday problem; review and provide corrective feedback toward improving the skill.
12. Learn and implement skills to reduce the disruptive influence of distractibility. (20, 21, 22)	20. Assess the client's typical attention span by having them do various tasks to the point that they indicate distraction; use this as an approximate measure of their typical attention span.
	21. Teach the client to break down tasks into meaningful units based on their demonstrated attention span.
	22. Teach the client to use timers or other cues to remind them to stop task units, in an effort to reduce the time they may be distracted and off-task (see *Mastery of Your Adult ADHD-Therapist Guide* by Safren et al.).
13. Identify, challenge, and change self-talk that contributes to maladaptive feelings and actions (23, 24)	23. Use cognitive therapy techniques to help the client identify maladaptive self-talk (e.g., that causing frustration, impulsivity, self-deprecation); challenge biases, and generate alternatives (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
	24. Assign homework asking the client to implement cognitive restructuring skills in relevant tasks; review and provide corrective feedback toward improving the skills.

14. Acknowledge procrastination and the need to reduce it. (25)

15. Learn and implement skills to reduce procrastination. (26, 27, 28)

16. Combine skills learned in therapy into a new daily approach to managing ADHD. (29, 30, 31)

25. Work with the client to identify positives and negatives of procrastinating toward the goal of engaging him/her in changing it.

26. Teach the client to apply problem-solving skills to planning as a first step in overcoming procrastination; for each plan, break it down into manageable time-limited steps to reduce the influence of distractibility.

27. Teach the client to apply cognitive restructuring skills to challenge thoughts encouraging the use of procrastination and embrace thoughts encouraging action.

28. Assign homework asking the client to accomplish identified tasks without procrastination using the techniques learned in therapy; review and provide corrective feedback toward improving the skill and decreasing procrastination.

29. Teach the client mediational and self-control strategies (e.g., "stop, look, listen, and think") to delay the need for instant gratification and inhibit impulses to achieve more meaningful, longer-term goals.

30. Select situations in which the client will be increasingly challenged to apply his/her new strategies for managing ADHD, starting with situations in which the client is highly likely to be successful (or assign "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

31. Use any of several techniques, including imagery, behavioral

	rehearsal, modeling, role-playing, or *in vivo* exposure/behavioral experiments to help the client consolidate the use of his/her new ADHD management skills.
17. Implement less impulsive social skills to minimize intrusions and offending others. (32, 33, 34, 35)	32. Use instruction, modeling, and role-playing to build the client's general social and/or communication skills (see *Social Effectiveness Training* by Turner, Beidel, and Cooley).
	33. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).
	34. Review social situations in which the client was intrusive or talked excessively without thoughtfulness; redirect for more social success using modeling, role-playing, and instruction.
	35. Teach the client problem-solving techniques that require thought before taking action to apply to interpersonal conflict situations (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma or "Negotiating Skills for Success" in the *Addiction Treatment Homework Planner,* 4th ed. by Finley and Lenz).
18. Learn and implement constructive coping strategies to use when the negative emotions associated with failure are a trigger for addiction. (36, 37)	36. Review specific instances of failure to learn and the negative emotions associated with the experience; focus on how addictive behavior was used to escape from negative emotions.

37. Role-play and model constructive alternative coping behaviors to use in failure-to-learn situations (e.g., cognitive refocusing, deep breathing, make lists, reduce distractions, shorten learning sessions, repeat instructions verbally).

19. Develop and implement an exercise program that includes exercising at a training heart rate for at least 20 minutes at least three times per week. (38)

38. Help the client develop an exercise program; increase the exercise by 10 percent each week until the client is exercising at a training heart rate for at least 20 minutes, at least three times a week.

20. Develop an aftercare program that includes regular attendance at recovery group meetings, getting a sponsor, and continuing the therapy necessary to bring ADHD and addiction under control. (39)

39. Help the client to develop an aftercare program that includes regular attendance at recovery group meetings, getting a sponsor, and continuing the therapy necessary to bring ADHD and addictive behavior under control.

21. Complete a re-administration of objective tests of ADHD and addiction as a means of assessing treatment outcome. (40)

40. Assess the outcome of treatment by re-administering to the client objective tests of ADHD; evaluate the results and provide feedback to the client.

22. Complete a survey to assess the degree of satisfaction with treatment. (41)

41. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type
	314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
	314.9	Attention-Deficit/Hyperactivity Disorder NOS
	300.4	Dysthymic Disorder
	312.30	Impulse-Control Disorder NOS
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	_____	_____
	_____	_____

ATTENTION-DEFICIT/INATTENTIVE DISORDER (ADD)

BEHAVIORAL DEFINITIONS

1. Demonstrates inability to sustain attention long enough to learn normally at work or school.
2. Fails to give sufficient attention to detail and tends to make careless mistakes.
3. Has difficulty sustaining attention at work, school, or play.
4. ADD symptoms and the frustration associated with them increase vulnerability to addictive behavior.
5. Often does not seem to listen when spoken to directly.
6. Often does not follow through on instructions and fails to finish tasks.
7. Reports difficulty organizing events, material, or time.
8. Avoids tasks and activities that require concentration.
9. Becomes too easily distracted by extraneous stimulation.
10. Often forgets daily obligations.

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LONG-TERM GOALS

1. Maintain a program of recovery, free from addiction and the negative effects of Attention-Deficit Disorder.
2. Demonstrate sustained attention and concentration for consistently longer periods of time.
3. Understand the negative influence of Attention-Deficit Disorder on substance use.
4. Structure a recovery program sufficient to maintain abstinence and reduce the negative effects of Attention-Deficit Disorder on learning and self-esteem.
5. Develop positive self-talk when faced with problems caused by Attention-Deficit Disorder or addiction.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Complete psychological testing or objective questionnaires for assessing ADD. (1)	1. Administer to the client psychological instruments designed to objectively assess ADD and substance abuse (e.g., Conners' Adult ADHD Rating Scales [CAARS]); give the client feedback regarding the results of the assessment.
2. Complete psychological testing to rule out emotional factors or learning disabilities as the basis for maladaptive behavior. (2)	2. Arrange for psychological testing to rule out emotional factors or learning disabilities as the basis for the client's maladaptive behavior; give feedback to the client and his/her family regarding psychological testing results.
3. Verbalize several reasons why attention deficit symptoms lead to addiction. (3, 4)	3. List the ways that using addictive behavior to cope with the symptoms of ADD and the

	feelings that result from it leads to powerlessness and unmanageability. 4. Probe the feelings the client had when trying to deal with the failure to learn due to symptoms of ADD, and discuss how chemical abuse was used to avoid uncomfortable feelings.
4. List the ways that using addiction to cope with symptoms of ADD and the feelings that result from it leads to powerlessness and unmanageability. (5)	5. Help the client to correlate ADD and addiction with powerlessness and unmanageability (or assign the client to complete a Step One exercise, such as in *The Alcoholism and Drug Abuse Patient Workbook* by Perkinson).
5. Verbalize the interpersonal difficulties caused or exacerbated by symptoms of ADD and substance abuse. (6, 7)	6. Probe the client's relationship problems caused or exacerbated by ADD and addiction. 7. Confront statements in which the client blames others for his/her impulsive behaviors and fails to accept responsibility for the consequences of his/her actions.
6. List the negative messages given to oneself in a learning situation and replace each with an encouraging, affirming message. (8, 9)	8. Assist the client in identifying distorted, negative self-talk with positive self-talk in a learning situation. 9. Train the client to replace negative expectations and disparaging self-talk with positive self-talk in a learning situation.
7. Identify specific instances when the negative emotions associated with failure to learn were a trigger for addiction, and verbalize constructive coping mechanisms to use in future learning situations. (10, 11)	10. Review specific instances of the client's failure to learn and the negative emotions associated with the experience; note if these emotions triggered addictive behavior as an escape. 11. Role-play and model constructive alternative coping behaviors (e.g., cognitive focusing, deep breathing, make lists, reduce distractions,

	shorten learning sessions, repeat instructions verbally) to deal with difficult and frustrating learning situations (or assign the client to complete the "Getting Organized" exercise in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lentz).
8. List how working a program of recovery can assist in eliminating the negative effects of ADD and addiction. (12, 13)	12. Help the client to see how working a program of recovery can aid in reducing the negative influences of ADD and addiction (e.g., going to meetings, talking regularly with a sponsor, and enjoying recreation with a new recovery peer group).
	13. Help the client to understand the AA concept of a higher power and teach the client the ways a higher power can assist him/her in recovery (e.g., turn problems over to God, practice regular prayer, and meditation).
9. Comply with a physician's evaluation to determine if psychopharmacological intervention is warranted; take any medications as directed. (14, 15)	14. Refer the client to a physician to determine if psychopharmacological intervention is warranted, and to order medications as indicated, titrate medications, and observe for side effects.
	15. Direct the staff to administer medications as ordered by the physician and to monitor for side effects and effectiveness.
10. Implement remedial procedures for learning disabilities that add to frustration. (16)	16. Refer the client to a special educator who will design remedial procedures for any learning disabilities that may be present in addition to ADD.
11. Keep lists of all scheduled activities and obligations and mark off each item as it is completed. (17)	17. Assist the client in developing calendars and lists to carry that detail activities and obligations.
12. List techniques that can be used to reduce the negative effects of ADD. (18)	18. Help the client to develop a list of the things he/she can do to reduce the negative effects of

ADD (e.g., reduce extraneous stimulation, make lists and reminders, take medication, utilize relaxation techniques, talk to someone, go to AA/NA meetings, engage in physical exercise); or assign "Symptoms and Fixes for ADD" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma.

13. Create and utilize a learning environment that is free enough of extraneous stimulation that productive learning can take place. (19)

19. Help the client develop a quiet place that is free of extraneous stimulation, where he/she can study, concentrate, and learn.

14. Implement coping skills when experiencing ADD symptoms or craving for addiction. (20, 21, 22, 23)

20. Teach the client relapse prevention techniques of going to meetings, talking to someone, calling a sponsor, implementing problem-solving techniques, utilizing relaxation skills, engaging in physical exercise, and turning worries over to a higher power (or assign the client "Negotiating Skills for Success" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

21. Using relaxation techniques (e.g., progressive relaxation, guided imagery, biofeedback); teach the client how to relax; assign him/her to relax twice a day for 10 to 20 minutes.

22. Encourage the client to implement relaxation skills twice a day as a coping and focusing mechanism when feeling tense and frustrated by a learning situation or when tempted to relapse into addictive behavior.

23. Help the client develop an exercise program, increasing the exercise until he/she is exercising at a

training heart rate at least three times a week for at least 20 minutes; encourage exercise as a means of reducing the level of stress and frustration or when tempted to relapse into addictive behavior.

15. Family members verbalize what each person can do to assist the client in recovery. (24, 25)

24. In a family session, teach the family members the connection between ADD and addiction, going over what each family member can do to assist the client in recovery (e.g., go to Al-anon meetings, reinforce positive coping skills, keep expectations realistic, go to an ADHD support group).

25. Provide the family members with information about ADHD (e.g., *You Mean I'm Not Lazy, Stupid, or Crazy?* by Kelly and Ramundo).

16. Complete a re-administration of objective tests of ADD as a means of assessing treatment outcome. (26)

26. Assess the outcome of treatment by re-administering to the client objective tests of ADD; evaluate the results and provide feedback to the client.

17. Complete a survey to assess the degree of satisfaction with treatment. (27)

27. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type
	314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
	314.9	Attention-Deficit/Hyperactivity Disorder NOS
	312.8	Conduct Disorder
	313.81	Oppositional Defiant Disorder
	312.9	Disruptive Behavior Disorder NOS
	312.30	Impulse-Control Disorder NOS
	315.9	Learning Disorder NOS
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
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	_____	_____

BORDERLINE TRAITS

BEHAVIORAL DEFINITIONS

1. Demonstrates extreme emotional reactivity (e.g., anger, anxiety, or depression) under minor stress, which usually does not last beyond a few hours to a few days.
2. Exhibits a pattern of intense, chaotic interpersonal relationships.
3. Presents with marked identity disturbance.
4. Experiences impulsive behaviors that are potentially self-damaging.
5. Reports recurrent suicidal gestures, threats, or self-mutilating behavior.
6. Verbalizes chronic feelings of emptiness or boredom.
7. Demonstrates frequent eruptions of intense, inappropriate anger.
8. Reports feeling that others are treating him/her unfairly or that they cannot be trusted.
9. Analyzes most issues in simple terms of right and wrong (black/white, trustworthy/deceitful) without regard for extenuating circumstances or complex situations.
10. Becomes very anxious with any hint of perceived abandonment in a relationship.

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LONG-TERM GOALS

1. Develop a program of recovery from addiction that reduces the impact of borderline traits on abstinence.
2. Develop and demonstrate coping skills to reduce mood swings and control impulses.
3. Understand how borderline traits can foster a pattern of continued addictive behavior.
4. Reduce the frequency of self-damaging behaviors (e.g., substance abuse, reckless driving, sexual acting out, binge eating, or suicidal behaviors).
5. Terminate dichotomous thinking, unmanaged anger, and/or fear of abandonment.

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SHORT-TERM OBJECTIVES

1. Discuss openly the history of difficulties that have led to treatment seeking. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Assess the client's experiences of distress and disability, identifying behaviors (e.g., parasuicidal acts, angry outbursts, overattachment), affect (e.g., mood swings, emotional overreactions, painful emptiness), and cognitions (e.g., biases such as dichotomous thinking, overgeneralization, catastrophizing) that will become the targets of therapy.
2. Explore the client's history of abuse and/or abandonment particularly in childhood years.
3. Validate the client's distress and difficulties as understandable given his/her particular circumstances, thoughts, and feelings.

2. Complete psychological testing or objective questionnaires for assessing symptoms associated with borderline personality. (4)	4. Administer to the client psychological instruments designed to objectively assess depression, suicidality, impulsivity, and/or aggression (e.g., The Millon Clinical Multiaxial Inventory [MCMI], Hamilton Depression Rating Scale [HDRS], Beck's Scale for Suicide Ideation [SSI], Aggressive Acts Questionnaire [AAQ], Barratt Impulsiveness Scale-11 [BIS-11]); give the client feedback regarding the results of the assessment.
3. Keep a daily record of negative emotions, thoughts, and behaviors. (5)	5. Assign the client to write a daily journal of emotions that he/she experienced, thoughts attached to them, and what actions resulted from those feelings for use throughout therapy.
4. Verbalize reasons why borderline traits make recovery from addictive behavior more difficult. (6, 7)	6. Assist the client in identifying borderline traits in their experience and how they have made recovery from addictive behavior more difficult.
	7. Help the client to see how poor impulse control, poor anger management, fear of abandonment, and intense mood swings increase the probability of addictive behavior (or assign "Analyzing Acting-Out Behavior" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz); explore instances when his/her borderline traits led to addictive behavior.
5. Verbalize an accurate and reasonable understanding of the process of therapy and what the therapeutic goals are. (8, 9)	8. Orient the client to dialectical behavior therapy (DBT), highlighting its multiple facets (e.g., support, collaboration, challenge, problem-solving, skill-building), and discuss dialectical/biosocial views of

borderline personality emphasizing constitutional and social influences on its features (see Cognitive-*Behavioral Treatment of Borderline Personality* by Linehan).

9. Throughout therapy, ask the client to read selected sections of books or manuals that reinforce therapeutic interventions (e.g., *Skills Training Manual for Treating BPD* by Linehan).

6. Verbalize a decision to work collaboratively with the therapist toward the therapeutic goals. (10)

10. Solicit from the client an agreement to work collaboratively within the parameters of the DBT approach to overcome the behaviors, emotions, and cognitions that have been identified as causing problems in his/her life.

7. Verbalize any history of self-mutilative and suicidal urges and behavior. (11, 12, 13, 14)

11. Probe the nature and history of the client's self-mutilating behavior.

12. Assess the client's suicidal gestures as to triggers, frequency, seriousness, secondary gain, and onset.

13. Arrange for hospitalization, as necessary, when the client is judged to be harmful to self.

14. Provide the client with an emergency help line telephone number that is available 24 hours a day.

8. Promise to contact the therapist or help line if experiencing a strong urge to engage in self-harm behavior. (15, 16)

15. Interpret the client's self-mutilation as an expression of the rage and helplessness that could not be expressed as a child victim of emotional abandonment or abuse; express the expectation that the client will control the urge for self-mutilation.

16. Elicit a promise (as part of a self-mutilation and suicide prevention contract) from the client that

	he/she will initiate contact with the therapist or a help line if a suicidal urge becomes strong and before any self-injurious behavior occurs; throughout the therapy process consistently assess the strength of the client's suicide potential.
9. Reduce actions that interfere with participating in therapy. (17)	17. Continuously monitor, confront, and problem-solve client actions that threaten to interfere with the continuation of therapy such as missing appointments, noncompliance, and/or abruptly leaving therapy.
10. Cooperate with an evaluation by a physician for psychotropic medication. (18, 19)	18. Assess the client's need for medication (e.g., selective serotonin reuptake inhibitors) and arrange for a prescription, if appropriate.
	19. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medication on his/her level of functioning.
11. Reduce the frequency of maladaptive behaviors, thoughts, and feelings that interfere with attaining a reasonable quality of life. (20)	20. Use validation, dialectical strategies (e.g., metaphor, devil's advocate) and problem-solving strategies (e.g., behavioral and solution analysis, cognitive restructuring, skills training, exposure; or assign "Plan Before Acting" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma) to help the client manage, reduce, or stabilize maladaptive behaviors (e.g., angry outbursts, binge drinking, abusive relationships, high-risk sex, uncontrolled spending, etc.), thoughts (e.g., all-or-nothing thinking, catastrophizing, personalizing) and feelings (e.g., rage, hopelessness, abandonment) (see *Cognitive-Behavioral*

Treatment of Borderline Personality by Linehan).

12. Participate in a group (preferably) or individual personal skills development course. (21, 22)

21. Conduct group or individual skills training tailored to the clients identified problem behavioral patterns (e.g., assertiveness for abusive relationships, cognitive strategies for identifying and controlling financial, sexual, and other impulsivity).

22. Use behavioral strategies (e.g., instruction, modeling, advising) to teach identified skills, strengthen them (e.g., through role-playing, exposure exercises), and facilitate incorporation into the client's everyday life (e.g., assign "Forming Stable Relationships" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

13. Verbalize a decreased emotional response to previous or current posttraumatic stress. (23)

23. After adaptive behavioral patterns and emotional regulation skills are evident, work with the client on remembering and accepting the facts of previous trauma, reducing denial and increasing insight into its effects, reducing maladaptive emotional and/or behavioral responses to trauma-related stimuli, and reducing self-blame.

14. Identify challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (24, 25, 26)

24. Explore the client's schema and self-talk that mediate his/her trauma-related and other fears, identify and challenge biases; assist him/her in generating thoughts that correct for the negative biases and build confidence (see *Cognitive Behavioral Therapy for Severe Personality Disorders* by Freeman).

25. Assign the client a homework

exercise in which he/she identifies fearful self-talk and creates reality-based alternatives; review and reinforce success, providing corrective feedback for failure (see "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma or "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck, Rush, Shaw, and Emery).

26. Reinforce the client's positive, reality-based cognitive messages that enhance self-confidence and increase adaptive action.

15. Participate in imaginal and/or *in vivo* exposure to trauma-related memories until talking or thinking about the trauma does not cause marked distress. (27, 28, 29)

27. Direct and assist the client in constructing a hierarchy of feared and avoided trauma-related stimuli.

28. Direct imaginal exposure to the trauma in session by having the client describe a chosen traumatic experience at an increasing, but client-chosen, level of detail; integrate cognitive restructuring and repeat until associated anxiety reduces and stabilizes; record the session and have the client listen to it between sessions (see "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma; *Posttraumatic Stress Disorder* by Resick and Calhoun); review and reinforce progress, problem-solve obstacles.

29. Assign the client a homework exercise in which he/she does an exposure exercise and records responses or listens to a recording of an in-session exposure (see *Posttraumatic Stress Disorder* by

	Resick and Calhoun); review and reinforce progress, problem-solve obstacles.
16. Verbalize a sense of self-respect that is not dependent on others' opinions. (30)	30. Help the client to value, believe, and trust in his/her evaluations of themselves, others, and situations and to examine them nondefensively and independent of others' opinions in a manner that builds self-reliance but does not isolate the client from others.
17. Engage in practices that help enhance a sustained sense of joy. (31)	31. Facilitate the client's personal growth by helping him/her choose experiences that strengthen self-awareness, personal values, and appreciation of life (e.g., insight-oriented therapy, spiritual practices, or other relevant life experiences; or assign the client to complete the "Learning to Self-Soothe" exercise from the *Addiction Treatment Homework Planner,* 4th ed., by Finley and Lenz).
18. Verbalize an understanding of how dichotomous thinking leads to interpersonal difficulties. (32, 33, 34)	32. Teach the client how dichotomous thinking leads to feelings of interpersonal distrust. 33. Challenge the extremes of the client's thinking as it relates to decisions about good or bad, or trustworthy or deceitful people. 34. Assist the client in realistically reviewing the strengths and weaknesses of his/her friends and family members (or assign "Seeing That We're All Just Human" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
19. Verbalize feelings of self-acceptance and self-confidence. (35)	35. Assist the client in resolving feelings of rejection from childhood in order to decrease his/her current feelings of vulnerability.

20. Verbalize ways in which a higher power can assist in resolving dependency needs. (36)

21. Exercise at least three times per week for at least 20 minutes. (37)

22. Write an aftercare program that lists resources that will be used when feeling angry, anxious, abandoned, or depressed, rather than reverting to addictive behavior. (38)

23. Family members verbalize what each can do to assist the client in recovery. (39, 40)

24. Complete a re-administration of objective tests to assess progress in resolving borderline traits as a means of assessing treatment outcome. (41)

25. Complete a survey to assess the degree of client's satisfaction with treatment. (42)

36. Teach the client about the higher power concept in 12-step recovery programs, and give examples of how he/she can turn problems over to the higher power while in recovery.

37. Help the client to develop an exercise program that will aid in reducing his/her stress level.

38. Assist the client in developing a structured aftercare program that lists resources he/she can use when feeling angry, anxious, abandoned, or depressed.

39. In a family session, review what each member can do to assist the client in recovery.

40. Provide the family members with information about borderline syndrome and the steps that the client must take to recover successfully.

41. Assess the outcome of treatment by re-administering to the client objective tests of progress in resolving borderline traits; evaluate the results and provide feedback to the client.

42. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	296.xx	Major Depressive Disorder
	300.4	Dysthymic Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	313.82	Identity Problem
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.7	Antisocial Personality Disorder
	301.0	Paranoid Personality Disorder
	_____	_____
	_____	_____

CHILDHOOD TRAUMA

BEHAVIORAL DEFINITIONS

1. Reports a history of childhood physical, sexual, or emotional abuse.
2. Uses addiction behaviors to escape emotional pain tied to childhood abuse.
3. Unresolved psychological conflicts caused by childhood abuse or neglect.
4. Experiences irrational fears, suppressed rage, low self-esteem, identity conflicts, depression, or anxious insecurity related to painful early life experiences.
5. Verbalizes intrusive memories, guilt, or emotional numbing from early childhood trauma.
6. Has unresolved emotions and maladaptive behavior that is the result of childhood trauma.
7. Demonstrates inability to trust others, bond in relationships, communicate effectively, and maintain healthy interpersonal relationships because of early childhood neglect or abuse.

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LONG-TERM GOALS

1. Resolve conflicting feelings that are associated with childhood traumas and terminate addiction, which has been used as a means of coping with those unresolved feelings.
2. Develop an awareness of how childhood issues have affected addiction.

3. Learn how childhood trauma resulted in interpersonal problems and addiction.
4. Maintain a program of recovery free of addiction and the negative effects of childhood trauma.
5. Learn to forgive perpetrators and turn them over to a higher power.
6. Resolve past childhood/family issues, leading to less fear, anger, and depression, and to greater self-esteem and confidence.

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SHORT-TERM OBJECTIVES

1. Verbalize powerlessness and unmanageability experienced as a child and directly relate these feelings to addiction. (1)

2. Describe the traumatic experiences that were endured as a child, and the feelings of helplessness, rage, hurt, and sadness that resulted from those experiences. (2)

3. Complete psychological testing or objective questionnaires for assessing childhood trauma. (3)

THERAPEUTIC INTERVENTIONS

1. Using an AA First Step exercise, help the client to see the powerlessness and unmanageability that resulted from using addiction to deal with negative feelings associated with childhood trauma (or assign the client to complete the Step One exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Explore the painful experiences endured in the client's family of origin, and help identify the unhealthy emotional and behavioral patterns that evolved from those experiences.

3. Administer to the client psychological instruments designed to objectively assess childhood trauma (e.g., Childhood Trauma Questionnaire [CTQ], Davidson Trauma Scale [DTS], Beck Depression Inventory-II [BDI-II], Beck Anxiety Inventory [BAI]);

	give the client feedback regarding the results of the assessment.
4. Identify the unhealthy rules and roles learned in the family of origin. (2, 4)	2. Explore the painful experiences endured in the client's family of origin, and help identify the unhealthy emotional and behavioral patterns that evolved from those experiences. 4. Teach the client about the unhealthy rules and roles that develop in dysfunctional families and help identify what role he/she played in the family dynamics (or assign "Changing from Victim to Survivor" in *the Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
5. Verbalize an understanding of how childhood abandonment, neglect, or abuse led to emotional and social problems. (5)	5. Help the client to understand the relationship between childhood trauma and current problems with trust, anger, self-esteem, or depression.
6. Identify a pattern of abusing substances as a means of escape from psychological pain associated with childhood traumas, and verbalize more constructive means of coping. (6, 7)	6. Explore the client's behavior of addiction as a means of coping with emotional pain, and assist him or her in identifying the self-defeating, negative consequences of this behavior. 7. Teach the client healthier and more constructive means of coping with emotional pain (e.g., sharing pain with others, attending AA meetings, confronting and then forgiving perpetrator, turning issues over to a higher power, setting healthy boundaries [see "Setting and Maintaining Boundaries" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz]).
7. Cooperate with an evaluation by a physician for psychotropic medication. (8, 9)	8. Assess the client's need for medication (e.g., selective serotonin reuptake inhibitors) and

arrange for prescription, if appropriate.

9. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medication on his/her level of functioning.

8. Participate in individual, parent-child, or group therapy sessions focused on recovery from childhood trauma. (10, 11, 12, 13)

10. With the child or adolescent client, refer or conduct group or individual therapy sessions based on multimodality trauma treatment (see March, Amaya-Jackson, Murray, and Schulte).

11. With the child or adolescent client, refer to or conduct individual or parent-child therapy sessions based on trauma-focused cognitive behavioral therapy (see *Treating Trauma and Traumatic Grief in Children and Adolescents* by Cohen, Mannarino, and Deblinger).

12. Refer or conduct group or individual therapy sessions based on dialectic behavior therapy for the adult client with prominent borderline traits (see the chapter on Borderline Traits in this *Planner*).

13. Refer or conduct individual therapy sessions based on cognitive behavioral therapy for PTSD for the adult client with prominent PTSD (see the chapter on PTSD in this Planner).

9. Verbalize an accurate understanding of the effects of childhood trauma and how it develops. (14, 15)

14. Discuss a biopsychosocial model of the effects of childhood trauma including exposure to trauma, intrusive recollection, unwarranted fears, anxiety, and a vulnerability to other negative emotions such as shame, anger, and guilt; normalize the client's experiences (see Cohen et al., 2006).

	15. Assign the client to read psychoeducational chapters of books or treatment manuals on the experience of childhood trauma that help explain its features and development while normalizing it (e.g., *It Happened to Me* by Carter).
10. Verbalize an understanding of the rationale for treatment of the effects of childhood trauma. (16)	16. Discuss how coping skills, cognitive restructuring, exposure, and psychoeducation help build confidence, desensitize and overcome fears, and see one's self, others and the world in a less fearful and/or depressing way (or assign client to complete *Reclaiming Your Life from a Traumatic Experience* by Olasov Rothbaum, Foa, and Hembree).
11. Learn and implement calming and coping strategies to manage challenging situations related to trauma. (17)	17. Teach the client strategies from approaches in *Anxiety Management Training* or *Stress Inoculation Training* such as relaxation, breathing control, covert modeling (i.e., imagining the successful use of the strategies) and/or role-playing (i.e., with the therapist or trusted other) for managing fears until a sense of mastery is evident (see *Cognitive Behavioral Psychotherapy* by Francis and Beidel or *Clinical Handbook for Treating PTSD* by Meichenbaum).
12. Acknowledge the need to implement anger control techniques; learn and implement anger management techniques. (18)	18. Teach the client anger management techniques (see *Overcoming Situational and General Anger* by Deffenbacher and McKay or assign "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); or see the chapter on Anger in this Planner).

13. Identify, challenge, and replace maladaptive self-talk with reality-based, empowering, self-accepting self-talk. (19, 20)

14. Participate in imaginal and *in vivo* exposure to trauma-related memories until talking or thinking about the trauma does not cause marked distress. (21, 22)

19. Explore the client's schema and self-talk that mediate his/her trauma-related fears; identify and challenge biases; assist him/her in generating appraisals that correct for the biases and build confidence.

20. Assign the client a homework exercise in which he/she practices identifying and challenging maladaptive self-talk (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); review and repeat toward developing and generalizing this skill.

21. Direct and assist the client in constructing a detailed narrative description of the trauma(s) for imaginal exposure (or assign "Describe the Trauma" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); construct a fear and avoidance hierarchy of feared and avoided trauma-related stimuli for *in vivo* exposure.

22. Have the client undergo imaginal exposure to the trauma by having him/her describe a traumatic experience at an increasing, but client-chosen, level of detail; repeat until associated anxiety reduces and stabilizes; record the session and have the client listen to it between sessions (see *Treating Trauma and Traumatic Grief in Children and Adolescents* by Cohen, Mannarino, and Deblinger); review and reinforce progress, problem-solve obstacles.

15. Learn and implement thought stopping to manage intrusive unwanted thoughts. (23)

23. Teach the client the thought-stopping technique in which he/she internally voices the word "stop" and/or imagines something representing the concept of stopping (e.g., a stop sign or light) immediately upon noticing unwanted trauma or otherwise negative unwanted thoughts (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

16. Learn and implement guided self-dialogue to manage thoughts, feelings, and urges brought on by encounters with trauma-related stimuli. (24)

24. Teach the client a guided self-dialogue procedure in which he/she learns to recognize maladaptive self-talk, challenge its biases, cope with engendered feelings, overcome avoidance, and reinforce his/her accomplishments; review and reinforce progress, problem-solve obstacles.

17. Learn and demonstrate honesty, openness, and assertiveness in communicating with others. (25, 26, 27)

25. Use modeling, role-playing, and behavior rehearsal to teach the client healthy problem-solving and communication skills to use in recovery (e.g., active listening, using "I messages," cooperation, compromise, and mutual respect).

26. Teach the client the healthy communication skills of being honest, asking for wants, and sharing feelings.

27. Using modeling, role-playing, and behavior rehearsal, teach the client healthy assertive skills; then practice these skills in several current problem situations.

18. Implement relapse prevention strategies for managing possible future trauma-related symptoms. (28, 29, 30, 31)

28. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of

symptoms, fear, or urges to avoid and a relapse with the decision to return to fearful and avoidant patterns.

29. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

30. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships.

31. Develop a "coping card" or other reminder on which coping strategies and other important information (e.g., "pace your breathing," "focus on the task at hand," "you can manage it," and "it will go away") are recorded for the client's later use.

19. Verbalize a plan as to how to fulfill the unmet needs of childhood now that adulthood has been reached. (32, 33)

32. Assist the client in identifying, understanding, and verbalizing unresolved needs, wishes, and wants from the childhood years (or assign "Corresponding with My Childhood Self" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz); then help him/her develop a written plan to meet each unmet need, wish, or want.

33. Have the client read material on resolving feelings surrounding childhood trauma (e.g., *Healing the Shame that Binds You* by Bradshaw and *Outgrowing the Pain* by Gil); then help him/her identify unresolved feelings, wishes, and wants.

20. List five ways a higher power can assist in recovery from childhood trauma and addiction. (34)

34. Teach the client about the AA/NA concept of a higher power, and how the higher power can assist

	him/her in forgiving others and reestablishing self-esteem.
21. Verbalize an understanding of the power of forgiving perpetrators. (34, 35, 36, 37)	34. Teach the client about the AA/NA concept of a higher power, and how the higher power can assist him/her in forgiving others and re-establishing self-esteem.
	35. Help the client to understand that often perpetrators were wounded children also, and need to be forgiven and turned over to a higher power in order to not harbor rage at them.
	36. Recommend the client read books on the topic of forgiveness (e.g., *Forgive and Forget* by Smedes, *When Bad Things Happen to Good People* by Kushner).
	37. Teach the client the benefits (e.g., release of hurt and anger, putting the issue in the past, opens the door for trust of others) of beginning a process of forgiveness (not necessarily forgetting or fraternizing with) of abusive adults.
22. Write a letter to the perpetrator, detailing the childhood abuse and its effect on one's thoughts, feelings, and behavior. (38, 39)	38. Assign the client to write a letter to his or her perpetrator detailing the emotional trauma that resulted from the abuse (or assign "Feelings and Forgiveness Letter" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
	39. Assign the client to write a forgiveness letter to the perpetrator of the abuse; process the letter.
23. Write a letter to each primary caregiver describing the childhood abuse and current feelings, wishes, and wants. (40)	40. Assist the client in writing a letter to each parent or primary caregiver, detailing his/her childhood abuse and sharing what the client wants from each person in recovery.
24. Verbalize an understanding of how the home group in AA/NA can	41. Help the client to see how the new home AA/NA group can help to

provide a substitute for an unhealthy family. (41)

25. Develop and agree to participate in an aftercare program to continue to recover from childhood abuse and addiction. (42)

26. Complete a re-administration of objective tests of childhood trauma effects as a means of assessing treatment outcome. (43)

27. Complete a survey to assess the degree of satisfaction with treatment. (44)

substitute for a healthy home that he/she never had.

42. Help the client to develop an aftercare program that includes regular attendance at recovery group meetings and the continued therapy necessary to recover from childhood trauma and addiction.

43. Assess the outcome of treatment by re-administering to the client objective tests of childhood trauma; evaluate the results and provide feedback to the client.

44. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	300.4	Dysthymic Disorder
	296.xx	Major Depressive Disorder
	300.02	Generalized Anxiety Disorder
	309.81	Posttraumatic Stress Disorder
	300.14	Dissociative Identity Disorder
	V61.21	Sexual Abuse of a Child (995.5, Victim)
	V61.21	Physical Abuse of a Child (995.5, Victim)
	V61.21	Neglect of Child (995.5, Victim)
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	_____	_____
	_____	_____

CHRONIC PAIN*

BEHAVIORAL DEFINITIONS

1. Uses addictive medications to control pain.
2. Experiences pain beyond the normal healing process (six months or more) and uses addictive medications as a primary coping skill.
3. Complains of generalized pain in many joints, muscles, and bones that debilitates normal functioning.
4. Overuse or use of increased amounts of medications with little, if any, pain relief.
5. Experiences tension, migraine, cluster, or chronic daily headaches of unknown origin.
6. Complains of chronic neck or back pain.
7. Experiences intermittent pain related to a physical disease.
8. Decreased or terminated activities (e.g., work, household chores, socializing, exercise, sex, or other pleasurable activities) because of pain and subsequent substance abuse.
9. Exhibits signs and symptoms of depression related to chronic pain syndrome.

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*Most of the content of this chapter (with slight revisions) originates from A. E. Jongsma and L. M. Peterson, *The Complete Adult Psychotherapy Treatment Planner, Fourth Edition* (New York: Wiley, 2006). Copyright © 2006 by A. E. Jongsma and L. M. Peterson. Reprinted with permission.

LONG-TERM GOALS

1. Discontinue opioid abuse and begin a program of recovery, using the 12-steps process as well as necessary pain management skills.
2. Regulate pain without addictive medications.
3. Find relief from pain and build renewed contentment and joy in performing activities of life.
4. Develop healthy options to deal with chronic pain.
5. Practice a program of recovery, including 12-step involvement and pain management skills.
6. Less daily suffering from pain and from substance abuse.

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SHORT-TERM OBJECTIVES

1. Describe the nature, history, impact of, and understood causes for chronic pain and substance abuse. (1, 2)
2. Cooperate with a thorough medical examination to rule out any alternative causes for the pain and to explore any new treatment possibilities. (3)
3. Follow through on a pain management and substance abuse program. (4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Gather a history and current status of the client's chronic pain and substance abuse.
2. Explore the changes in the client's mood, attitude, and social, vocational, and familial/marital roles that have occurred in response to pain and substance abuse.
3. Refer the client to a physician or clinic to undergo a thorough examination, so as to rule out any undiagnosed condition and to receive recommendations on any further treatment options.
4. Discuss with the physician the use of medications to manage chronic pain and withdrawal from addictive substances.

	5. Make a referral to a pain management specialist and substance abuse program of the client's choice and have him/her sign appropriate releases for the therapist to have progress updates from the program and to coordinate services.
	6. Elicit from the client a verbal commitment to cooperate with the pain management specialists, headache clinic, or rehabilitation program.
4. Complete psychological testing or objective questionnaires for assessing the level of pain. (7)	7. Administer to the client psychological instruments designed to objectively assess chronic pain (e.g., McGill Pain Questionnaire Short Form [MPQ-SF], Psychosocial Pain Inventory [PSPI]); give the client feedback regarding the results of the assessment.
5. Complete a thorough medication review by a physician who is a specialist in dealing with chronic pain and substance abuse. (8)	8. Ask the client to complete a medication review with a physician, including a discussion of the use of methadone, and buprenorphine for pain management and opioid withdrawal.
6. Verbalize a statement of ownership of the pain and the addiction. (9)	9. Assist the client in working through the defenses that prevent him/her from owning the pain and the substance abuse as his/hers.
7. Participate in a cognitive behavioral group therapy for pain management. (10)	10. Form a small, closed enrollment group (4–8 clients) for pain management (see *Group Therapy for Patients with Chronic Pain* by Keefe, Beaupre, Gil, Rumble, and Aspnes).
8. Verbalize an understanding of pain. (11)	11. Teach the client key concepts of rehabilitation versus biological healing, conservative versus aggressive medical interventions,

acute versus chronic pain, benign versus nonbenign pain, cure versus management, appropriate use of medication, role of self-regulation techniques, and so on.

9. Verbalize an understanding of the rationale for treatment. (12, 13)

12. Teach the client a rationale for treatment that helps him/her understand that thoughts, feelings, and behavior can affect pain and emphasize the role that the client can play in managing his/her own pain (or assign the client to complete *Managing Chronic Pain* by Otis).

13. Assign the client to read sections from books or treatment manuals that describe pain conditions and their cognitive behavioral treatment (e.g., *The Chronic Pain Control Workbook* by Catalano and Hardin).

10. Identify and monitor specific pain triggers. (14)

14. Teach the client self-monitoring of his/her symptoms; ask the client to keep a pain journal that records time of day, where and what he/she was doing, the severity, and what was done to alleviate the pain (or assign "Pain and Stress Journal" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); process the journal with the client to increase insight into the nature of the pain, cognitive, affective, and behavioral triggers, and the positive or negative effect of the interventions they are currently using.

11. Learn and implement somatic skills such as relaxation and/or biofeedback to reduce pain level. (15, 16, 17, 18, 19)

15. Teach the client relaxation skills (e.g., progressive muscle, guided imagery, slow diaphragmatic breathing) and how to better discriminate between relaxation and tension; teach the client how to apply these skills to his/her

daily life (see *Progressive Relaxation Training* by Bernstein and Borkovec).

16. Refer the client for, or conduct, biofeedback training (e.g., EMG for muscle tension-related pain, thermal for migraine pain); assign practice of the skill at home.

17. Identify areas in the client's life where he/she can implement skills learned through relaxation or biofeedback.

18. Assign a homework exercise in which the client implements somatic pain management skills and records the result; review and process during the treatment session.

19. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *Progressive Relaxation Training* by Bernstein and Borkovec).

12. Incorporate physical therapy/exercise into daily routine. (20)

20. Refer the client for physical therapy if pain is heterogeneous; request an individually tailored exercise program, if indicated, that is approved by his/her personal physician.

13. Learn mental coping skills and implement with somatic skills for managing acute pain. (21)

21. Teach client distraction techniques (e.g., pleasant imagery, counting techniques, alternative focal point) and how to use them with relaxation skills for the management of acute episodes of pain.

14. Increase the level and range of activity by identifying and engaging in pleasurable activities. (22)

22. Ask the client to create a list of activities that are pleasurable to him/her (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by

Jongsma); process the list, developing a plan of increasing the frequency of engaging in the selected pleasurable activities.

15. Identify negative pain-related thoughts and replace them with more positive coping-related thoughts. (23, 24, 25)

23. Explore the client's schema and self-talk that mediate their pain response, challenging the biases; assist him/her in generating thoughts that correct for the biases, facilitate coping, and build confidence in managing pain.

24. Assign the client a homework exercise in which he/she identifies negative pain-related self-talk and positive alternatives (or assign "Correcting Distorted Thinking" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz); review and reinforce success, providing corrective feedback toward improvement.

25. Assign the client to read about cognitive restructuring in relevant books or treatment manuals (e.g., *The Chronic Pain Control Workbook* by Catalano and Hardin or *Managing Chronic Pain* by Otis).

16. Integrate and implement new mental, somatic, and behavioral ways of managing pain. (26)

26. Assist the client in integrating learned pain management skills (e.g., relaxation, distraction, activity scheduling) into a progressively wider range of daily activities; record and review.

17. Problem-solve obstacles to implementation of new ways to manage pain. (27)

27. Teach the client problem-solving skills to apply to removal of obstacles to implementing new skills.

18. Implement relapse prevention strategies for managing future challenges. (28, 29, 30)

28. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of pain or old habits (e.g., a "bad day")

	and relapse with the persistent return of pain and previous cognitive and behavioral habits that exacerbate pain.
	29. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur, using the strategies learned during therapy.
	30. Follow-up with the client periodically to problem-solve difficulties and reinforce successes.
19. Identify the steps of the "dance of pain" in his/her life. (31)	31. Develop with the client the metaphor of pain as a dance (see *Making Peace with Chronic Pain* by Hunter), working to identify the particular steps of the dance as it moves through his/her daily life; challenge the client to either alter the steps of his/her present dance or to design a completely new dance.
20. Verbalize an increased awareness of the mind-body connection. (32, 33)	32. Ask the client to read *Peace, Love, and Healing* by Siegel, *The Mind/Body Effect* by Benson, or attend a seminar related to holistic healing for insight into the mind-body connection.
	33. Assist the client in beginning to see the connection between chronic pain, substance abuse, and chronic stress.
21. Utilize spirituality to reduce tension and pain. (34, 35)	34. Teach the client about prayer and meditation and then assist him/her in implementing meditation into daily life.
	35. Visit with a member of the clergy and learn how to turn things over to a higher power.
22. Verbalize new, healthier attitudes about pain and substance abuse. (36, 37)	36. Confront the client's negative attitudes about pain and substance abuse and assist him/her in

replacing them with more positive, constructive attitudes.

37. Assist the client in becoming capable of seeing humor in more of his/her daily life; promote this expansion with the use of humorous teaching tapes, Dr. Seuss books, telling jokes, and assigning the client to watch one or two comedy movies each week.

23. Investigate the use of alternative pain remedies to reduce doctor visits and/or dependence on medication. (38)

38. Explore the client's alternatives to doctors and medications to remove or reduce his/her pain (or assign "Alternative Methods for Managing Pain" or "Coping with Addiction and Chronic Pain" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

24. Make changes in diet that will promote health and fitness. (39)

39. Refer the client to a dietitian for consultation about eating and nutritional patterns; process the results of the consultation, identifying changes he/she can make, and how he/she might start implementing these changes.

25. Complete a re-administration of objective tests of chronic pain and substance abuse as a means of assessing treatment outcome. (40)

40. Assess the outcome of treatment by re-administering to the client objective tests of chronic pain and substance abuse; evaluate the results and provide feedback to the client.

26. Complete a survey to assess the degree of satisfaction with treatment. (41)

41. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	307.89	Pain Disorder Associated with Both Psychological Factors and an Axis III Disorder
	307.80	Pain Disorder Associated with Psychological Factors
	300.81	Somatization Disorder
	300.11	Conversion Disorder
	296.3x	Major Depressive Disorder, Recurrent
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
	304.80	Polysubstance Dependence
	304.00	Opioid Dependence
	_____	_____
	_____	_____

CONDUCT DISORDER/DELINQUENCY

BEHAVIORAL DEFINITIONS

1. Persistent refusal to comply with rules or expectations in the home, school, or community.
2. Excessive fighting, intimidation of others, cruelty or violence toward people or animals, and destruction of property.
3. History of stealing at home, at school, or in the community.
4. School adjustment characterized by disrespectful attitude toward authority figures, frequent disruptive behaviors, and detentions or suspensions for misbehavior.
5. Repeated conflict with authority figures at home, at school, or in the community.
6. Impulsivity as manifested by poor judgment, taking inappropriate risks, and failing to stop and think about consequences of actions.
7. Numerous attempts to deceive others through lying, conning, or manipulating.
8. Consistent failure to accept responsibility for misbehavior accompanied by a pattern of blaming others.
9. Little or no remorse for misbehavior.
10. Lack of sensitivity to the thoughts, feelings, and needs of other people.
11. Multiple sexual partners, lack of emotional commitment, and engaging in unsafe sexual practices.
12. Use of mood-altering substances on a regular basis.
13. Participation in gang membership and activities.

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LONG-TERM GOALS

1. Comply with rules and expectations in the home, school, and community consistently.
2. Eliminate all illegal and antisocial behavior.
3. Terminate all acts of violence or cruelty toward people or animals and stop any destruction of property.
4. Demonstrate marked improvement in impulse control.
5. Express anger in a controlled, respectful manner on a consistent basis.
6. Resolve the core conflicts that contribute to the emergence of conduct problems.
7. Parents establish and maintain appropriate parent-child boundaries, setting firm, consistent limits when the client acts out in an aggressive or rebellious manner.
8. Demonstrate empathy, concern, and sensitivity for the thoughts, feelings, and needs of others on a regular basis.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Identify situations, thoughts, and feelings that trigger angry feelings, problem behaviors, and the targets of those actions. (1)	1. Thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts, feelings, and actions that have characterized his/her anger responses.
2. Cooperate with a medical evaluation to assess possible organic contributors to poor anger control. (2)	2. Refer the client to a physician for a complete physical exam to rule out organic contributors (e.g., brain damage, tumor, elevated testosterone levels, etc.) to poor anger control.
3. Complete psychological testing. (3)	3. Conduct or arrange for psychological testing to help

assess conduct disorder traits (e.g. Conduct Disorder Rating Seale [CDRS] by Gilliam, Overt Aggression Scale [OAS] by Yudofsky, et. al., or Conduct Disorder Scale [CDS] by Gilliam) and whether a comorbid condition (e.g., depression, Attention-Deficit/Hyperactivity Disorder [ADHD]) is contributing to anger control problems; follow-up accordingly with client and parents regarding treatment options.

4. Complete a substance abuse evaluation and comply with the recommendations offered by the evaluation findings. (4)

4. Arrange for a substance abuse evaluation and/or treatment for the client.

5. Cooperate with the recommendations or requirements mandated by the criminal justice system. (5, 6, 7)

5. Consult with criminal justice officials about the appropriate consequences for the client's destructive or aggressive behaviors (e.g., pay restitution, community service, probation, intensive surveillance).

6. Consult with parents, school officials, and criminal justice officials about the need to place the client in an alternative setting (e.g., foster home, group home, residential program, or juvenile detention facility).

7. Encourage and challenge the parents not to protect the client from the natural or legal consequences of his/her destructive or aggressive behaviors.

6. Cooperate with a physician evaluation for possible treatment with psychotropic medications to assist in anger and behavioral control and take medications consistently, if prescribed. (8)

8. Assess the client for the need for psychotropic medication to assist in control of anger; refer him/her to a physician for an evaluation for prescription medication; monitor prescription compliance, effectiveness, and side effects;

provide feedback to the prescribing physician.

7. Recognize and verbalize how feelings are connected to misbehavior. (9)

8. Increase the number of statements that reflect the acceptance of responsibility for misbehavior. (10, 11, 12)

9. Agree to learn alternative ways to think about and manage anger and misbehavior. (13, 14)

9. Actively build the level of trust with the client through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings instead of acting them out; assist the client in making a connection between his/her feelings and reactive behaviors.

10. Firmly confront the client's antisocial behavior and attitude, pointing out consequences for himself/herself and others.

11. Confront statements in which the client lies and/or blames others for his/her misbehaviors and fails to accept responsibility for his/her actions.

12. Explore and process the factors that contribute to the client's pattern of blaming others (e.g., harsh punishment experiences, family pattern of blaming others).

13. Assist the client in reconceptualizing anger as involving different components (cognitive, physiological, affective, and behavioral) that go through predictable phases (e.g., demanding expectations not being met leading to increased arousal and anger leading to acting out) that can be managed.

14. Assist the client in identifying the positive consequences of managing anger and misbehavior (e.g., respect from others and self, cooperation from others, improved

physical health, etc.); ask the client to agree to learn new ways to conceptualize and manage anger and misbehavior.

10. Learn and implement calming strategies as part of a new way to manage reactions to frustration. (15)

15. Teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a tailored strategy for responding appropriately to angry feelings when they occur.

11. Identify, challenge, and replace self-talk that leads to anger and misbehavior with self-talk that facilitates a more constructive reactions. (16)

16. Explore the client's self-talk that mediates his/her angry feelings and actions (e.g., demanding expectations reflected in "should," "must," or "have to" statements); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration.

12. Learn and implement thought-stopping to manage intrusive unwanted thoughts that trigger anger and acting out. (17)

17. Assign the client to implement a "thought-stopping" technique on a daily basis between sessions (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); review implementation; reinforce success, providing corrective feedback toward improvement.

13. Verbalize feelings of frustration, disagreement, and anger in a controlled, assertive way. (18)

18. Use instruction, modeling, and/or role-playing to teach the client assertive communication; if indicated, refer him/her to an assertiveness training class/group for further instruction.

14. Learn and implement problem-solving and/or conflict resolution skills to manage interpersonal problems constructively. (19)

19. Teach the client conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise);

use modeling, role-playing, and behavior rehearsal to work through several current conflicts.

15. Practice using new calming, communication, conflict resolution, and thinking skills in session with the therapist and during homework exercises. (20, 21)

20. Assist the client in constructing and consolidating a client-tailored strategy for managing anger that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to their needs.

21. Use any of several techniques, including relaxation, imagery, behavioral rehearsal, modeling, role-playing, or feedback of videotaped practice in increasing challenging situations to help the client consolidate the use of his/her new anger management skills.

16. Practice using new calming, communication, conflict resolution, and thinking skills in homework exercises. (22)

22. Assign the client homework exercises to help them practice newly learned calming (e.g., use "Safe and Peaceful Place Meditation" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz), assertion (e.g., "Learning to Ask Instead of Demand" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz), conflict-resolution (e.g., assign the exercise "Filing a Complaint" from the *Adolescent Psychotherapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis), or cognitive restructuring skills (e.g., assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma) as needed; review and process toward the goal of consolidation.

17. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (23)

18. Identify social supports that will help facilitate the implementation of new skills. (24)

19. Parents learn and implement Parent Management Training skills to recognize and manage the problem behavior of the client. (25, 26, 27, 28, 29)

23. Monitor the client's reports of angry outbursts toward the goal of decreasing their frequency, intensity, and duration through the client's use of new anger management skills (or assign "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); review progress, reinforcing success and providing corrective feedback toward improvement.

24. Encourage the client to discuss and/or use his/her new anger and conduct management skills with trusted peers, family, or otherwise significant others who are likely to support his/her change.

25. Use a Parent Management Training approach, beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (e.g., see *Parenting the Strong-willed Child* by Forehand and Long; *Living with Children* by Patterson; or assign the parents to read *Parenting Your Out-of-Control Teenager* by Sells).

26. Teach the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.

27. Teach the parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise), use of clear direct instruction, time out, and other loss-of-privilege practices for problem behavior.
28. Assign the parents home exercises in which they implement and record results of implementation exercises (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.
29. Ask the parents to read parent training manuals (e.g., *Parenting Through Change* by Forgatch) or watch videotapes demonstrating the techniques being learned in session (see *Troubled Families—Problem Children* by Webster-Stratton).

20. Increase compliance with rules at home and school. (30)

30. Design a reward system and/or contingency contract for the client and meet with school officials to reinforce identified positive behaviors at home and school and deter impulsive or rebellious behaviors.

21. Parents verbalize appropriate boundaries for discipline to prevent further occurrences of abuse and to ensure the safety of the client and his/her siblings. (31)

31. Explore the client's family background for a history of neglect and physical or sexual abuse that may contribute to his/her behavioral problems; confront the

	client's parents to cease physically abusive or overly punitive methods of discipline; implement the steps necessary to protect the client or siblings from further abuse (e.g., report abuse to the appropriate agencies; remove the client or perpetrator from the home).
22. Identify and verbally express feelings associated with past neglect, abuse, separation, or abandonment. (32)	32. Encourage and support the client in expressing feelings associated with neglect, abuse, separation, or abandonment and help process (e.g., assign the task of writing a letter to an absent parent or use the empty chair technique).
23. Increase verbalizations of empathy and concern for other people. (33)	33. Use role-playing and role reversal techniques to help the client develop sensitivity to the feelings of others in reaction to his/her antisocial behaviors.
24. Increase the frequency of responsible and positive social behaviors. (34, 35, 36)	34. Direct the client to engage in three altruistic or benevolent acts (e.g., read to a developmentally disabled students, mow grandmother's lawn) before the next session to increase his/her empathy and sensitivity to the needs of others.
	35. Assign homework designed to increase the client's empathy and sensitivity toward the thoughts, feelings, and needs of others (e.g., "Headed in the Right Direction" from the *Adolescent Psychotherapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis).
	36. Place the client in charge of tasks at home (e.g., preparing and cooking a special dish for a family get-together, building shelves in the garage, changing oil in the car) to demonstrate confidence in his/her ability to act responsibly.

25. Establish and maintain steady employment. (37, 38)

26. Identify and verbalize the risks involved in sexually promiscuous behavior. (39)

27. Parents participate in marital therapy. (40)

28. Complete a re-administration of objective tests of conduct disorder as a means of assessing treatment outcome. (41)

29. Complete a survey to assess the degree of satisfaction with treatment. (42)

37. Refer the client to vocational training to develop basic job skills and find employment.

38. Encourage and reinforce the client's acceptance of the responsibility of a job, the authority of a supervisor, and the employer's rules.

39. Provide the client with sex education; discuss the risks involved with sexually promiscuous behaviors; and explore the client's feelings, irrational beliefs, and unmet needs that contribute to the emergence of sexually promiscuous behaviors.

40. Assess the marital dyad for possible substance abuse, conflict, or triangulation that shifts the focus from marriage issues to the client's acting out behaviors; refer for appropriate treatment, if needed.

41. Assess the outcome of treatment by re-administering to the client objective tests of conduct disorder; evaluate the results and provide feedback to the client.

42. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	312.81	Conduct Disorder, Childhood-Onset Type
	312.82	Conduct Disorder, Adolescent-Onset Type
	313.81	Oppositional Defiant Disorder
	312.9	Disruptive Behavior Disorder NOS
	314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
	314.9	Attention-Deficit/Hyperactivity Disorder NOS
	312.34	Intermittent Explosive Disorder
	V71.02	Child or Adolescent Antisocial Behavior
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	V71.09	No Diagnosis on Axis II
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	_____	_____

DANGEROUSNESS/LETHALITY

BEHAVIORAL DEFINITIONS

1. Exhibits low frustration tolerance and poor impulse control, with a history of violence.
2. Abuses mood-altering substances, in spite of many negative consequences, including dangerous effects to self.
3. Uses substance abuse to cope with negative emotions such as anger, hurt, embarrassment, or frustration.
4. Demonstrates poor anger management skills.
5. Acts aggressively and is uncooperative with staff and peers.
6. Refuses to listen to parents or authority figures.
7. Has attempted suicide or homicide.
8. Makes threats of physical harm to self or others.
9. Danger of violence escalates under the influence of mood-altering substances.

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LONG-TERM GOALS

1. Develop a program of recovery, free from substance abuse and dangerous/lethal behaviors.
2. Terminate all acts that are dangerous to self or others.
3. Verbalize the core conflicts that lead to dangerous/lethal behaviors.
4. Recognize the first signs of anger and use behavioral techniques to control it.

5. Increase self-esteem, purpose for living, and learn how to help others in recovery.
6. Maintain appropriate parent-child boundaries, setting firm limits when the client acts dangerously toward self or others.

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SHORT-TERM OBJECTIVES

1. Sign a contract agreeing to not harm self or others and to obey all rules while in treatment. (1, 2)

2. Cooperate with a referral for a medical evaluation. (3, 4)

3. Cooperate with a biopsychosocial examination. (5, 6)

THERAPEUTIC INTERVENTIONS

1. Request that the client sign a no-harm contract detailing that he/she will not harm himself/herself; ask client to promise to tell a staff member if he/she feels an urge to be harmful to self or others.
2. Read the client the rules of treatment and ask him/her to sign an agreement that he/she will abide by all of the rules.
3. Refer the client to be examined by a physician and/or psychiatrist for a medical evaluation; encourage an assessment for substance abuse effects, organic or neurological basis for violence, and the need for psychotropic medication.
4. Monitor the client for medication compliance, effectiveness, and side effects.
5. Complete a biopsychosocial (e.g., family history of violence and substance abuse, childhood history of violence, chemical dependence, social relationships).

6. Meet with family members to obtain their perspective on the client's substance abuse and violence.

4. Complete psychological testing or objective questionnaires for assessing violence toward self and others. (7)

7. Administer to the client psychological instruments designed to objectively assess violence toward self or others (e.g., Beck Scale for Suicide Ideation [BSS], Domestic Violence Inventory [DVI]); give the client feedback regarding the results of the assessment.

5. Identify three somatic sensations that occur with building hurt, fear, or anger. (8)

8. Assist the client in identifying three somatic feelings that accompany feelings of hurt, fear, and anger (or assign "Is My Anger Due to Feeling Threatened?" or "Is My Anger Due to Unmet Expectations?" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz); assess how the client copes with these feelings.

6. Identify the current degree of threat that exists to self or others. (9, 10)

9. Assess the client for his/her degree of urge to harm self, degree of plan development, access to means of harm, history of previous attempts, degree of hopelessness or hurt related to relationship dissolution, and any other factors that increase suicide risk; consider inpatient treatment if indicated.

10. Assess the client for his/her degree of urge to harm others, degree of plan development, history of violence, threats made, relationship conflict, possessiveness or stalking of victim, criminal history, history of restraining orders, use of substance abuse to cope with anger, hurt, or depression; consider the duty to warn if risk is significant.

7. List five things the client can do when angry to cope with feelings. (11)

11. Help the client to make a list of five things he/she can do when feeling angry to cope with angry feelings (e.g., relaxing using deep breathing; processing the situation to stop, think, and plan accurately; separating from the situation to give the client time to calm down before responding).

8. Keep an anger journal describing the situations that cause anger. (12, 13)

12. Teach the client how to keep an anger journal, using subjective units of distress as a measurement of the intensity of the dangerous/lethal feelings, giving the anger a subjective unit of distress score from 1 (as little anger as possible) to 100 (as much anger as possible).

13. Review the client's anger journal and teach the client how inaccurate thinking leads to angry feelings and how thinking accurately can eliminate aggression.

9. Practice relaxation skills twice each day for 10 to 20 minutes. (14)

14. Using progressive relaxation techniques, teach the client how to relax (or assign the "Safe and Peaceful Place Meditation" exercise in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz); ask the client to rate the extent of relaxation achieved on a scale of 1 to 10.

10. Participate in physical exercise each day. (15)

15. Encourage the client to participate in exercise for at least 20 minutes each day; monitor implementation, reinforcing success, and redirecting for failure.

11. Identify the possible causes of dangerous lethal behaviors. (16)

16. Explore with the client his/her family-of-origin-issues (e.g., physical abuse, abandonment, sexual abuse, gang affiliation, parental chemical dependence, etc.) that may have led to dangerous lethal behaviors (or assign

	the "Understanding Family History" exercise in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
12. List five ways dangerous and lethal behaviors contribute to substance abuse and vice versa. (17, 18)	17. Help the client to make a list of five ways that dangerous lethal behaviors have contributed to substance abuse, and have the client share this list in group.
	18. Assist the client in listing five ways that substance abuse contributes to lethal behaviors (e.g., deepens depression and shame, reduces inhibition to reason with self or others).
13. Verbalize acceptance of powerlessness and unmanageability of substance abuse and dangerous lethal behaviors. (19)	19. Discuss the meaning of powerlessness and unmanageability in the recovery program and show how this step can be used to manage dangerous lethal behaviors.
14. Verbalize an understanding of AA's Steps Two and Three and list three ways a higher power can assist in recovery. (20)	20. Teach the client about Steps Two and Three of AA (or assign the Step Two and Step Three exercises in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson); then show three ways a higher power can assist him/her in recovery.
15. Complete an AA Step Four and Step Five exercise that includes a history of past assets and liabilities, discussing the exact nature of wrongs. (21, 22)	21. Have the client complete a Fourth Step inventory of who are the targets of anger and resentment, why they are resented, and how this has affected the client (or assign the Step Four exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
	22. As part of a Fifth Step, ask the client to share how he/she has wronged others.
16. Parents verbalize an understanding of their child's aggressiveness and its interaction with substance abuse. (23, 24)	23. Meet with family members and discuss dangerousness and lethal behaviors and substance abuse, talking about what the client is

going to do differently in recovery.

24. Assign the parents to read *Parenting Your-Out-of-Control Teenager* by Sells and discuss with them measures to reestablish control over their child.

17. Sign a behavior contract that lists all behavior expected in recovery and the consequences of failing to meet these contractual obligations. (25)

25. Develop with the family a behavior contract that outlines what the client will do in recovery and the consequences of failing to meet these contractual obligations.

18. Complete a re-administration of objective tests of violence toward self and others as a means of assessing treatment outcome. (26)

26. Assess the outcome of treatment by re-administering to the client objective tests of violence toward self and others; evaluate the results and provide feedback to the client.

19. Complete a survey to assess the degree of satisfaction with treatment. (27)

27. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	312.8	Conduct Disorder
	313.81	Oppositional Defiant Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	312.34	Intermittent Explosive Disorder
	309.4	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
	296.xx	Major Depressive Disorder
	V71.01	Adult Antisocial Behavior

Axis II:	301.0	Paranoid Personality Disorder
	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
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DEPENDENT TRAITS

BEHAVIORAL DEFINITIONS

1. Passively submits to the wishes, wants, and needs of others to the exclusion of the client's own wishes.
2. Dependent traits have fostered engagement in addictive behavior.
3. Chronically fears interpersonal abandonment and desperately clings to destructive relationships.
4. Goes to excessive lengths to gain acceptance from others to the point of volunteering to do unpleasant things.
5. Has a history of being anxious about making decisions without an excessive amount of advice and support from others.
6. Lacks ability to trust own judgment about everyday life decisions.
7. Persistently feels worthless, helpless, and believes rejection is inevitable.
8. Needs others to assume responsibility and make most major decisions.
9. Fears group situations unless certain of being accepted.
10. Chronically feels alienation from others.

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LONG-TERM GOALS

1. Recovery from substance abuse, which reduces the impact of dependent traits on addiction.
2. Demonstrate increased independence and self-confidence through autonomous decision making, honest expression of feelings and ideas, and reduced fear of rejection.
3. Decrease dependence on relationships while beginning to meet own needs, build confidence, and practice assertive skills.
4. Demonstrate healthy communication that is honest, open, and self-disclosing.
5. Reduce the frequency of behaviors exclusively designed to please others.
6. Reduce feelings of alienation by learning similarity to others who were raised in a more normal home.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Acknowledge the feelings of powerlessness and unmanageability that result from dependent traits and addictive behavior. (1)	1. Probe the feelings of powerlessness that the client experienced as a child and how these feelings are similar to how he/she feels when engaging in dependent and addictive behavior.
2. Complete psychological testing or objective questionnaires for assessing dependent traits. (2)	2. Administer to the client psychological instruments designed to objectively assess dependent traits and addictive behavior (e.g., Millon Clinical Multiaxial Inventory-III [MMCI-III]); give the client feedback regarding the results of the assessment.
3. Identify at least five dynamics of early family life that contributed to developing dependent traits. (3, 4, 5, 6)	3. Educate the client about the childhood etiology of his/her fear of making decisions and how this is not appropriate as an adult (or

assign "Understanding Family History" in the *Addiction Treatment Homework Planner,* 4th ed. by Finley and Lenz).

4. Explore how the dysfunctional family's inconsistent rules led to the client's fear of failure.
5. Assist the client in understanding how his/her early childhood experiences led to a fear of decision making that might lead to abandonment, rejection, and neglect, and the assumption of a childlike role as a defense (or assign "Taking Steps Toward Independence" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).
6. Teach the client about how low self-esteem and fear of making the wrong choice resulted from being raised in a home where family members were overly controlling and critical.

4. Identify five incidents in which dependent traits were used to avoid the anxiety of making decisions that could have resulted in failure. (7, 8, 9)

7. Explore the influence that the client's fear and shame had on choosing a life-style of dependent traits and addictive behavior.
8. Ask the client to identify at least five instances in which he/she avoided decisions out of fear of failure or rejection (or assign "Making Your Own Decisions" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
9. Probe the client's inability to trust his/her own judgment; raise his/her awareness of this tendency and explore its origins.

5. Verbalize an understanding of how dependent traits contributed to addictive behavior. (10)

10. Discuss the relationship between the client's dependent traits and his/her addictive behavior; explore

	how dependency has fostered addictive behavior.
6. Identify abandonment experiences in the family of origin, and how this has influenced current relationships. (5, 11, 12)	5. Assist the client in understanding how his/her early childhood experiences led to a fear of decision making that might lead to abandonment, rejection, and neglect, and the assumption of a childlike role as a defense (or assign "Taking Steps Toward Independence" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
	11. Raise the client's awareness of his/her tendency to take over the child role in relationships; explore causes for this pattern in the client's childhood abandonment and rejection experiences (or assign "Satisfying Unmet Emotional Needs" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
	12. Explore the client's childhood experiences of abandonment and neglect; relate these to his/her dependent traits and addictive behavior.
7. Share the feeling of worthlessness that was learned in the family and relate this feeling to addictive behavior as a coping mechanism. (13)	13. Assist the client in identifying a pattern of using addictive behavior as an escape from feelings of anxiety and worthlessness.
8. Report three incidents per week in which relaxation skills were implemented to counteract anxiety in interpersonal situations. (14, 15)	14. Teach the client relaxation procedures (e.g., deep muscle release, rhythmic deep breathing, positive imagery) as a coping technique for anxiety.
	15. Role-play instances in which the client could implement relaxation techniques as a healthy escape from anxiety; monitor and reinforce implementation of this skill in daily life.

9. Openly share thoughts, feelings, and problems in each therapy session. (16, 17)

10. Discuss with therapist two incidents per week of telling the truth rather than only saying what the other person wanted to hear. (18, 19)

11. Verbalize an understanding of how dependent traits contributed to choosing partners and friends who were demeaning and controlling. (20)

12. Implement decision-making skills in at least three situations per week; document and report on the

16. Explore how the client's family responded to expressions of feelings, wishes, and wants, and why the client became anxious when he/she expressed a choice, feeling, or decision.

17. Educate the client about healthy interpersonal relationships based on openness, respect, and honesty, and explain the necessity of sharing feelings to build trust and mutual understanding (or assign the "Negotiating Skills for Success" or "Building My Support Network" exercise in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

18. Teach the client about how the behavior of telling other people what we think they want to hear—rather than the truth—is based on a fear of rejection, learned in the family; use behavior rehearsal to teach the client more honest communication skills (or assign the client to complete the "Working Toward Independence" exercise in the *Addiction Homework Planner,* 4th ed. by Finley and Lenz).

19. Teach the client the assertive formula of "I feel _____ when you _____; I would prefer it if _____," role-playing several applications to his/her life; have the client journal one assertive situation each day.

20. Review the client's choice of friends and intimate partners; relate his/her dependency traits to selection of demeaning and controlling people.

21. Teach problem-solving skills (e.g., identify the problem, brainstorm alternate solutions, examine the

process and feelings associated with the experience. (21, 22, 23)

advantages and disadvantages of each option, select an option, implement a course of action, and evaluate the result); role-play solving a problem drawn from the client's life experience.

22. Educate the client about how the fear of making decisions is based on low self-esteem (or assign the client to complete the "Learning to Self-Soothe" exercise in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

23. Assign the client to implement decision-making skills at least three times per week and record the process and feelings; review, reinforce, and redirect when necessary.

13. Discuss fears related to attendance at recovery group meetings and verbalize specific plans to deal with each fear. (24, 25)

24. Teach the client how becoming actively involved in a 12-step recovery group can aid in building trust in others and confidence in self.

25. Probe the relationship between the client's dependent traits and fear of attending recovery group meetings; assist the client in identifying coping skills (e.g., relaxation techniques, going to meetings with a sponsor, positive self-talk, assertiveness skills) to overcome fears.

14. List reasons why regular attendance at recovery group meetings is necessary in arresting dependent traits and addictions. (26, 27)

26. Assist the client in developing an aftercare plan centered on regular attendance at a 12-step recovery group meeting.

27. Discuss how the 12-step home group can be like the healthy family the client never had; help the client list reasons why he/she needs such a group to recover (e.g., "I need love and support

	from people in recovery," "I want a new family to help me," "I need brothers and sisters in recovery to keep me in recovery").
15. Report on successfully contacting a sponsor within the 12-step community. (28)	28. Educate the client about the importance of sponsorship within the 12-step community and facilitate his/her establishment of a relationship with a temporary sponsor.
16. List ways that belief in an interaction with a higher power can reduce fears and aid in recovery. (29)	29. Teach the client about the positive ways that faith in a higher power can aid in recovery and arrest the fear associated with dependent traits and addiction (e.g., regular attendance at worship services, daily prayer, and meditation).
17. Verbalize a feeling of serenity that results from turning problems that are out of one's own control over to a higher power. (30)	30. Review and reinforce the client's enactment of faith in a higher power in his/her daily life.
18. Read portions of recovery literature six days per week and share insights obtained with others. (31)	31. Assign the client to read recovery literature (e.g., Alcoholic Anonymous *Big Book*) and process the material in an individual or group therapy session.
19. Practice assertiveness skills and keep a daily journal of the times the skills were used in interpersonal conflict. (19, 32)	19. Teach the client the assertive formula of "I feel _____ when you _____; I would prefer it if _____," role-playing several applications to his/her life; have the client journal one assertive situation each day.
	32. Use modeling, behavior rehearsal, and role-playing to teach the client healthy assertiveness skills; then assign the application of these skills to several current problem situations.
20. Complete a re-administration of objective tests of dependent traits as a means of assessing treatment outcome. (33)	33. Assess the outcome of treatment by re-administering to the client objective tests of dependent traits; evaluate the results and provide feedback to the client.

21. Complete a survey to assess the degree of satisfaction with treatment. (34)

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34. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	300.00	Anxiety Disorder NOS
	300.02	Generalized Anxiety Disorder
	300.23	Social Phobia
	300.21	Panic Disorder with Agoraphobia
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	301.50	Histrionic Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

DEPRESSION

BEHAVIORAL DEFINITIONS

1. Feels sad or down most of the days of the week.
2. Engages in addictive behavior as a means of escaping from feelings of sadness, worthlessness, and helplessness.
3. Presents with vegetative symptoms (e.g., sleep disturbance, appetite disturbance, anhedonia, lack of energy, weight change).
4. Verbalizes persistent feelings of helplessness, hopelessness, worthlessness, and/or guilt.
5. Lacks energy and has excessive fatigue.
6. Reports poor concentration, indecisiveness.
7. Demonstrates low self-esteem.
8. Experiences mood-congruent hallucinations or delusions.
9. Reports suicidal thoughts.
10. Expresses a wish to die without a suicidal thought or plan.

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LONG-TERM GOALS

1. Elevate mood and develop a program of recovery free from addiction.
2. Decrease dysfunctional thinking and increase positive, self-enhancing self-talk.
3. Understand affective disorders and how these symptoms increase vulnerability to addiction.
4. Develop a program of recovery that includes healthy exercise, relaxation, and eating and sleeping habits.
5. Improve social skills and attend recovery groups regularly.
6. Resolve grief and guilt issues and increase feelings of self-worth.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe current and past experiences with depression and other mood episodes, including their impact on function and attempts to resolve or treat them. (1, 2)	1. Assess current and past mood episodes including their features, frequency, intensity, and duration; impact on role functioning; previous treatments; and response to treatments (e.g., Clinical Interview supplemented by the *Inventory to Diagnose Depression* by Zimmerman, Coryell, Corenthal, and Wilson). 2. Utilize a graphic display, such as a timeline, to help the client identify the pattern of his/her mood symptoms.
2. Facilitate an assessment of personal and family history of depression and other mood symptoms, allowing family participation. (3, 4)	3. Ask family, friends, and caregivers about the client's own and the family's history of depression symptoms. 4. Provide the client, family, or caretaker with sleeping, eating, and

activity logs on which to document current levels of functioning.

3. Complete psychological testing to assess the depth of depression, the need for antidepressant medication, and suicide prevention measures. (5)

5. Arrange for the administration of an objective assessment instrument for evaluating the client's depression and suicide risk (e.g., Beck Depression Inventory-II and/or Beck Hopelessness Scale); evaluate results and give feedback to the client.

4. Cooperate with suicide prevention measures. (6, 7)

6. Coordinate an immediate referral to a crisis residential facility or inpatient psychiatric ward to provide a safe, supervised environment for the suicidal client.

7. Develop a structured suicide prevention plan (see the Suicidal Ideation chapter in this *Planner*).

5. Obtain a complete physical evaluation to rule out medical etiologies for depression symptoms. (8)

8. Refer the client to a physician for a complete physical examination to rule out medical etiologies for depression.

6. Verbalize the powerlessness and unmanageability that result from using addictive behavior to cope with depression. (9, 10)

9. Using a 12-step recovery program's Step One exercise, help the client to admit powerlessness and unmanageability over addictive behavior and depression (or assign "Consequences of Continuing Addictive Lifestyles" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

10. Teach the client that addictive behavior results in negative psychological effects such as depression, and that addiction is often used to escape from these same psychological symptoms, creating a vicious cycle.

7. Identify a pattern of using drug or alcohol abuse as a means of escaping from depression, and

11. Confront the client's addictive behavior as a means of coping with depression; assist him/her in

verbalize more constructive means of coping. (11, 12)	identifying the self-defeating, negative consequences of this behavior. 12. Process healthier, more constructive means of coping with depression (e.g., sharing pain with others, attending 12-step recovery program meetings, developing positive cognitions, taking medication, turning conflicts over to a higher power).
8. Cooperate with a referral to a physician for a psychotropic medication evaluation. (13)	13. Refer the client to a physician for an evaluation as to the need for psychotropic medications.
9. Take prescribed psychotropic medications responsibly; report the side effects and effectiveness of medications to the appropriate professional. (14)	14. Educate the client about the use, and expected benefits of medication; review effects of the medications with the client and medical staff to identify possible side effects; monitor the client's medication compliance and effectiveness.
10. Obtain an adequate, stable sleep pattern. (15, 16)	15. Assess and address basic sleep hygiene needs (e.g., decrease stimulants in the evening; have a quiet, comfortable place to sleep; spend time winding down; same wake-up time) and behavioral strategies (e.g., implementing relaxation techniques, staying in bed awake no more than 15 minutes) to reinforce structure to sleep routine. 16. Refer the client for a sleep disorder evaluation.
11. Verbalize an understanding of the development and rationale for treatment of depression. (17)	17. Discuss factors related to the development and maintenance of the client's depression and how treatment will target these factors for change.
12. Identify and replace cognitive self-talk that supports depression. (18, 19, 20, 21)	18. Assist the client in developing an awareness of his/her automatic thoughts that reflect a depressogenic schema.

19. Assign the client to keep a daily journal of automatic thoughts associated with depressive feelings (e.g., "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma; "Correcting Distorted Thinking" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz; or "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck, Rush, Shaw, and Emery); process the journal material to challenge depressive thinking patterns and replace them with reality-based thoughts. 
20. Do "behavioral experiments" in which depressive automatic thoughts are treated as hypotheses/predictions, reality-based alternative hypotheses/predictions are generated, and both are tested against the client's past, present, and/or future experiences. 
21. Reinforce the client's positive, reality-based cognitive messages that enhance self-confidence and increase adaptive action (see "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma). 

 13. Learn and use behavioral strategies to overcome depression. (22, 23, 24)

22. Assist the client in developing coping strategies (e.g., more physical exercise, less internal focus, increased social involvement, more assertiveness, greater need sharing, more anger expression, etc.) for feelings of depression; reinforce success. 
23. Engage the client in "behavioral activation" by scheduling activities that have a high likelihood for

pleasure and mastery (see "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); use rehearsal, role-playing, and role reversal, as needed, to assist adoption in the client's daily life; reinforce success. EBT

24. Employ self-reliance training in which the client assumes increased responsibility for routine activities (e.g., cleaning, cooking, and shopping); reinforce success. EBT

EBT 14. Identify important people in your life, past and present, and describe the quality, good and bad, of those relationships. (25)

25. Assess the client's "interpersonal inventory" of important past and present relationships and evidence of potentially depressive themes (e.g., grief, interpersonal disputes, role transitions, and interpersonal deficits). EBT

EBT 15. Verbalize any unresolved grief issues that may be contributing to depression. (26)

26. Explore the role of unresolved grief issues as they contribute to the client's current depression (see the Grief/Loss Unresolved chapter in this *Planner*). EBT

EBT 16. Learn and implement assertive communication. (27)

27. Use modeling and/or role-playing to train the client in assertiveness; if indicated, refer him/her to an assertiveness training class/group for further instruction. EBT

EBT 17. Learn and implement problem-solving and/or conflict resolution skills to resolve interpersonal problems. (28, 29, 30)

28. Teach the client conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise) to help alleviate depression; use modeling, role-playing, and behavior rehearsal to work through several current conflicts. EBT

29. Help the client resolve depression related to interpersonal problems through the use of reassurance and support, clarification of cognitive

	and affective triggers that ignite conflicts, and active problem solving (or assign "Applying Problem Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
	30. In conjoint sessions, help the client resolve interpersonal conflicts.
18. Learn and implement effective decision-making skills. (31)	31. Teach the client a decision-making strategy that involves identifying one problem at a time, breaking the decision down into relevant parts, examining the pros and cons of relevant choices, and coming to a decision based on that procedure; discourage the client from making major life decisions (when possible) until after his/her mood disorder improves.
19. Implement a regular exercise regimen as a depression reduction technique. (32, 33)	32. Develop and reinforce a routine of physical exercise for the client.
	33. Recommend that the client read and implement an exercise program (e.g., *Exercising Your Way to Better Mental Health* by Leith).
20. Learn and implement relapse prevention skills. (34)	34. Build the client's relapse prevention skills by helping him/her to identify early warning signs of relapse, reviewing skills learned during therapy, and developing a plan for managing challenges.
21. Write an autobiography detailing the exact nature of wrongs, and turn past misbehavior over to a higher power. (35)	35. Using a 12-step recovery program's Step Four inventory, assign the client to write an autobiography that details exactly how he/she has hurt others; help him/her turn over past misbehavior to a higher power.
22. Read aloud positive, self-enhancing statements each morning. (36)	36. Help the client to develop a list of 10 accurate, self-enhancing statements to read each morning.

23. Encourage someone in recovery each day. (37)

24. Write a plan and express hope for the future. (38)

25. Write down five things each night for which gratitude is felt. (39)

26. Attend group therapy sessions to share thoughts and feelings that are related to depression, and how addictive behavior has been used to avoid these negative feelings. (40)

27. Write an aftercare program. (41)

28. Family members verbalize a connection between depression and addictive behavior. (42)

29. Family members verbalize what each can do to assist the client in recovery. (43, 44)

37. Help the client to understand that he/she is needed in a 12-step recovery program to help others; discuss specific ways to help others, and how this builds the client's self-esteem and self-worth.

38. Assist the client in developing future plans, and show that these plans create new hope for tomorrow; list future plans in writing.

39. Teach the client about the 12-step recovery program's concept of *an attitude of gratitude*; assign him/her to write down five things for which he/she is grateful each day.

40. Direct or refer the client to group therapy sessions in which he/she is encouraged to share feelings of depression, allowing for feedback of empathy, acceptance, and affirmation from group members.

41. Help the client to develop a written aftercare program that includes regular attendance at 12-step recovery groups and any other therapy that the client needs to improve his/her health.

42. Discuss with family members the connection between depression and addictive behavior.

43. In a family session, review what each member can do to assist the client in recovery.

44. Provide the family members with information about depression (e.g., recommend reading *What to Do When Someone You Love Is Depressed* by Golant or *When Someone You Love Is Depressed* by Rosen and Amador) and the steps that the client must take to recover successfully.

30. Complete a re-administration of objective tests of depression as a means of assessing treatment outcome. (45)

31. Complete a survey to assess the degree of satisfaction with treatment. (46)

45. Assess the outcome of treatment by re-administering to the client objective tests of depression; evaluate the results and provide feedback to the client.

46. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.0	Adjustment Disorder with Depressed Mood
	309.28	Adjustment Disorder with Mixed Anxiety and Depressed Mood
	311	Depressive Disorder NOS
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	300.4	Dysthymic Disorder
	301.13	Cyclothymic Disorder
	296.2x	Major Depressive Disorder, Single Episode
	296.3x	Major Depressive Disorder, Recurrent
	295.70	Schizoaffective Disorder
	V62.82	Bereavement
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

EATING DISORDERS

BEHAVIORAL DEFINITIONS

1. Expresses a fear of loss of control over eating; feels that eating cannot be stopped and/or the amount of food consumed cannot be controlled.
2. Has intense fear of gaining weight or becoming fat.
3. Presents with marked body image disturbance: perceives self as overweight, even when thin.
4. Engages in intermittent starving, gorging, purging, use of laxatives and/or enemas, excessive exercise, or other dysfunctional behaviors aimed at weight control.
5. Reports chronic feelings of depression revolving around the belief that one is fat.
6. Reports frequent, unsuccessful attempts to bring the abnormal eating behavior under control.
7. Uses food consumption as a means of relaxation or escape from stress.
8. Verbalizes that self-evaluation is unduly influenced by body shape and weight.
9. Becomes very anxious when thinking of body weight, food, or eating.
10. Uses addictive behavior to cope with anxiety.

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LONG-TERM GOALS

1. Eat nutritionally and develop healthy, realistic attitudes about body image and weight.
2. Terminate overeating, purging, use of laxatives, enemas, and/or excessive exercise.
3. Terminate addictive behavior.
4. Develop the ability to control the impulse to overeat.
5. Learn and demonstrate constructive strategies to cope with dysphoric moods.
6. Replace negative, self-defeating addictive thinking about food and body image with more realistic, self-enhancing self-talk.

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SHORT-TERM OBJECTIVES

1. Honestly describe the pattern of eating including types, amounts, frequency of food consumed or hoarded. (1, 2, 3, 4)

2. Describe any regular use of unhealthy weight control behaviors. (5)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the amount, type, and pattern of the client's food intake (e.g., too little food, too much food, binge eating, or hoarding food).
3. Compare the client's calorie consumption with an average adult rate of 1,500 calories per day to determine over- or undereating.
4. Confront client's minimization and denial of the eating disorder behavior and its related, distorted thinking.
5. Assess for the presence of self-induced vomiting behavior by the client to purge himself/herself of

	calorie intake; assess for the client's misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise; monitor on an ongoing basis.
3. Complete psychological testing or objective questionnaires for assessing eating disorders. (6)	6. Administer to the client psychological instruments designed to objectively assess eating disorders (e.g., Eating Inventory, Stirling Eating Disorders Scales, Eating Disorders Inventory [EDI]); give the client feedback regarding the results of the assessment.
4. Cooperate with a complete physical exam. (7)	7. Refer the client to a physician for a physical exam, and stay in close consultation with the physician as to the client's medical condition and nutritional habits.
5. Cooperate with a dental exam. (8)	8. Refer the client to a dentist for a dental exam.
6. Cooperate with an evaluation by a physician for psychotropic medication. (9)	9. Assess the client's need for psychotropic medications (e.g., SSRIs); arrange for a physician to evaluate for and then prescribe psychotropic medications, if indicated.
7. Take medications as prescribed, and report effectiveness and side effects. (10)	10. Monitor the client's psychotropic medication prescription compliance, effectiveness, and side effects.
8. Cooperate with admission to inpatient treatment, if indicated. (11)	11. Refer the client for hospitalization, as necessary, if his/her weight loss becomes severe and physical health is jeopardized, or if he/she is severely depressed or suicidal.
9. Verbalize an accurate understanding of how eating disorders develop. (12)	12. Discuss with the client a model of eating disorders development that includes concepts such as sociocultural pressures to be thin, vulnerability in some individuals to overvalue body shape and size

in determining self-image, maladaptive eating habits (e.g., fasting, binging), maladaptive compensatory weight management behaviors (e.g., purging), and resultant feelings of low self-esteem (see *Overcoming Binge Eating* by Fairburn).

10. Verbalize an understanding of the rationale and goals of treatment. (13, 14)

13. Discuss a rationale for treatment that includes using cognitive and behavioral procedures to break the cycle of thinking and behaving that promotes poor self-image, uncontrolled eating, and unhealthy compensatory actions while building physical and mental health-promoting eating practices (or assign "Creating a Preliminary Health Plan" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

14. Assign the client to read psycho-educational chapters of books or treatment manuals on the development and treatment of eating disorders (e.g., *Overcoming Binge Eating* by Fairburn or *Overcoming Your Eating Disorder* by Agras).

11. Keep a journal of food consumption. (15)

15. Assign the client to self-monitor and record food intake, thoughts, and feelings (or assign "A Reality Journal: Food, Weight, Thoughts, and Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma or "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck, Rush, Shaw, and Emery); process the journal material to challenge maladaptive patterns of thinking and behaving, and replace them with adaptive alternatives.

12. Establish regular eating patterns by eating at regular intervals and consuming at least the minimum daily calories necessary to progressively gain weight. (16, 17, 18)

16. Establish a minimum daily caloric intake for the client and assist him/her in meal planning.

17. Establish healthy weight goals for the client per the Body Mass Index (BMI = pounds of body weight × 700/height in inches/height in inches; normal range is 19 to 24 and below 17 is medically critical), the Metropolitan Height and Weight Tables, or some other recognized standard.

18. Monitor the client's weight and give realistic feedback regarding body thinness.

13. Attain and maintain balanced fluids and electrolytes, as well as resumption of reproductive functions. (19, 20)

19. Monitor the client's fluid intake and electrolyte balance; give realistic feedback regarding progress toward the goal of balance.

20. Refer the client back to the physician at regular intervals if fluids and electrolytes need monitoring due to poor nutritional habits.

14. Identify and develop a hierarchy of situations that trigger unhealthy eating or weight loss practices. (21, 22)

21. Assess the nature of any external cues (e.g., persons, objects, and situations) and internal cues (thoughts, moods, images, and impulses) that precipitate the client's uncontrolled eating and/or compensatory weight management behaviors.

22. Direct and assist the client in construction of a hierarchy of high-risk internal and external triggers for uncontrolled eating and/or compensatory weight management behaviors.

15. Identify, challenge, and replace self-talk and beliefs that promote the eating disorder. (15, 23, 24)

15. Assign the client to self-monitor and record food intake, thoughts, and feelings (or assign "A Reality Journal: Food, Weight, Thoughts,

and Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma or "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck, Rush, Shaw, and Emery); process the journal material to challenge maladaptive patterns of thinking and behaving, and replace them with adaptive alternatives.

23. Assist the client in developing an awareness of his/her automatic thoughts and underlying assumptions, associated feelings and actions that lead to maladaptive eating and weight control practices (e.g., poor self-image, distorted body image, perfectionism, fears of failure and/or rejection, fear of sexuality).

24. Assist the client in the identification of negative cognitive messages (e.g., catastrophizing, exaggerating) that mediate his/her dysfunctional eating behavior, then train the client to establish realistic cognitive messages regarding food intake and body size (or assign "Fears Beneath the Eating Disorder" from the *Adolescent Psychotherapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis).

16. Participate in exposure exercises to build skills in managing urges to use maladaptive weight control practices. (25)

25. Conduct repeated exposure and ritual prevention to the client's high-risk situations (e.g., exposure to eating a high-carbohydrate food while resisting the urge to self-induce vomiting); select initial exposures that have a high likelihood of being a successful experience for the client; prepare and rehearse a plan for the session; do cognitive restructuring within

	and after the exposure; review/process the session with the client.
17. Complete homework assignments involving behavioral experiments and/or exposure exercises. (26)	26. Assign the client a homework exercise in which he/she repeats the in-session behavioral experiment or exposure exercise between sessions and records responses; review the homework, doing cognitive restructuring, reinforcing success, and providing corrective feedback toward improvement.
18. Discuss important people in your life, past and present, and describe the quality, good and bad, of those relationships. (27)	27. Conduct Interpersonal Therapy, assessing the client's "interpersonal inventory" of important past and present relationships and evidence of themes that may be supporting the eating disorder (e.g., interpersonal disputes, role transitions, and/or interpersonal deficits).
19. Learn and implement problem-solving and/or conflict resolution skills to resolve interpersonal problems. (28, 29, 30)	28. Teach the client conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise); use modeling, role-playing, and behavior rehearsal to work through several current conflicts.
	29. Help the client resolve interpersonal problems through the use of reassurance and support, clarification of cognitive and affective triggers that ignite conflicts, and active problem-solving.
	30. In conjoint sessions, help the client resolve interpersonal conflicts.
20. Implement relapse prevention strategies for managing possible future anxiety symptoms. (31, 32, 33, 34)	31. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of distress, urges, or to avoid the

	anxiety-producing situation, and relapse with the decision to return to the cycle of maladaptive thoughts and actions (e.g., feeling anxious, binging, then purging).
	32. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.
	33. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to previous external or internal cues that arise) to prevent relapse.
	34. Schedule periodic "maintenance" sessions to help the client maintain therapeutic gains and adjust to life without the eating disorder.
21. Verbalize an understanding of how fear of abandonment is expressed in eating disorders and addictive behavior. (35, 36)	35. Probe the relationship between the client's feelings of anger, sadness, or fear of abandonment and the eating disorder and other addictive behaviors.
	36. Assist the client in identifying triggers for fear of abandonment, and possible historical causes for these feelings being so predominant.
22. Practice the healthy communication skills of listening to others, the use of "I statements," and sharing feelings. (37)	37. Teach the client how to listen, use "I statements," and share feelings; assign him/her to implement listening skills and "I message" communication in daily life, and then monitor, review, reinforce, and redirect as indicated.
23. Make a list of 10 positive body characteristics. (38)	38. Assign the client the task of listing 10 positive characteristics of his/her body; process the list.
24. Practice relaxation techniques two times a day for 10 to 20 minutes per session. (39)	39. Teach the client relaxation techniques (e.g., progressive relaxation, deep breathing, and/or

guided imagery); urge implementation of relaxation techniques as a substitute for eating disorder or addictive behaviors during times of anxiety or stress.

25. Complete a re-administration of objective tests of eating disorders and a means of assessing treatment outcome. (40)

40. Assess the outcome of treatment by re-administering to the client objective tests of eating disorders; evaluate the results and provide feedback to the client.

26. Complete a survey to assess the degree of satisfaction with treatment. (41)

41. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	307.1	Anorexia Nervosa
	307.51	Bulimia Nervosa
	307.50	Eating Disorder NOS
	296.xx	Major Depressive Disorder
	300.4	Dysthymic Disorder
	_____	_____
	_____	_____
Axis II:	301.50	Histrionic Personality Disorder
	301.6	Dependent Personality Disorder
	300.3	Obsessive-Compulsive Disorder
	_____	_____
	_____	_____

FAMILY CONFLICTS

BEHAVIORAL DEFINITIONS

1. Exhibits a pattern of family conflicts leading to dysfunctional relationships and addiction.
2. Describes a family that engages in repeated physical fights, verbal arguments, and/or unresolved disputes.
3. Demonstrates poor communication skills, leading to an inability to solve family problems.
4. Admits to physical or verbal abuse of family members.
5. Uses addiction to cope with feelings of anger, alienation, or depression related to conflict within the family.
6. The family has a history of unresolved intrafamily conflicts leading to distrust and alienation.
7. Experiences long periods of noncommunication with family members due to unresolved conflicts.
8. Describes a family that is not supportive to recovery.
9. Has a history of addiction in family members, leading to a poor recovery environment.
10. An adult child continues to live in the parental home without consistent efforts to become financially and emotionally independent and emancipate.

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LONG-TERM GOALS

1. Maintain a program of recovery that is free of addiction and family conflict.
2. Learn and demonstrate healthy communication and conflict resolution skills, leading to harmony within the family and the cessation of addiction.
3. Forgive family members' past misdeeds and begin a life of harmony with each family member.
4. Terminate addiction and implement more healthy coping behaviors to deal with conflicts within the family.
5. Begin to emancipate from the parents in a healthy way by making reasonable arrangements for independent living.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Verbalize the powerlessness and unmanageability that have resulted from using addictive behavior to cope with family conflicts. (1, 2)	1. Help the client to see the powerlessness and unmanageability that have resulted from using addiction to cope with family conflicts. 2. Assist the client in understanding the vicious cycle that results from reacting to family conflicts with addictive behaviors.
2. Identify the nature and history of current family conflicts. (3)	3. Explore the client's history to identify the nature of and causes for the current family conflicts.
3. Complete or give permission for a significant other to complete a survey of the client's family. (4)	4. Administer to the client or a significant other an objective survey (e.g., Family Environment Scale [FES] by Moos and Moos; Family Relationship Inventory [FRI] by Michaelson, Bascom, Nash, Morrison and Taylor; or Family System Test [FAST] by Gehring) to assess the client's

	family; give the client feedback regarding the results of the assessment.
4. Verbalize how current family conflicts relate to conflicts in the family of origin, which were experienced as a child. (5)	5. Help the client to see the relationship between the family of origin childhood conflicts and current family conflicts; assign him/her to write a detailed account of how the two are related.
5. Acknowledge that attempts to seize power and control within the family lead to unhealthy interpersonal relationships. (6, 7)	6. Assist the client in identifying how he/she has attempted to seize power and control within the family.
	7. Teach the client about respect for independence and autonomy in a healthy family, and help the client to see how power struggles led to unresolved family conflicts.
6. Family members give individual perspectives on current conflicts. (8)	8. In a family session make a list of current family conflicts from each member's perspective (or assign "Identifying Conflict Themes" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
7. Family members identify and implement changes that each one must make to reduce conflict. (9, 10, 11)	9. Assist each family member in identifying what he/she could do to reduce family conflicts and heal the wounds of the past.
	10. Develop a written contract that outlines what each family member will do to resolve family conflicts.
	11. Review the family members' implementation of changes to reduce conflict; reinforce success, confront projection, and redirect for failures.
8. In a family session, verbalize how addiction fosters misunderstanding and conflict and how conflict fosters addiction. (12)	12. Help the family members understand how family conflict increases the probability of addictive behavior and how addictive behavior increases the probability of family conflict.

9. Write a letter to each family member taking responsibility for past misdeeds, stating remorseful feelings, and asking for support from each member during recovery. (13, 14)

10. Family members read letters sharing how they feel and stating what behavior they would like from the client during his/her recovery. (15)

11. Family members and the client participate in Family Behavior Therapy. (16)

12. Family members identify realistic personal and family goals. (17)

13. Family members participate in developing a treatment plan sequence. (18)

14. Identify any emergency or potential emergency situations that need to be addressed. (19)

13. Help the client write a letter to each family member, taking responsibility for problems in the past, sharing his/her feelings, and asking for what he/she would like from each family member to support his/her recovery.

14. Confront the client when he/she blames others and does not accept responsibility for his/her own role in the family conflict.

15. Help each family member write a letter to the client stating how they feel, and asking for what they would like from him/her during recovery; ask each member to read the letter to the client in a family session.

16. Conduct or refer family to Family Behavioral Therapy (see *Family Behavior Therapy* by Donahue and Azrin).

17. Have each family member identify personal and family goals; discuss identifying a set of realistic goals that can be tracked through therapy.

18. Facilitate the development of a treatment plan sequence by asking family members to rate goals in terms of importance; use this information and other relevant considerations to lay out a treatment plan.

19. Teach the client skills (e.g., assertion and problem-solving skills to make requests of creditors, landlords, etc.) tailored to identifying emergency or potential emergency situations (e.g., violence, having utilities turned off due to nonpayments, medical emergencies, loss of job, eviction, unsanitary conditions).

15. Decrease contact with people, places, and activities associated with drug use; increase time with safe people and activities. (20)

20. Teach the client to identify, monitor, and eliminate or control people, places, or activities that increase the likelihood of drug use and associated behavior problems, and increase time spent in activities that decrease their likelihood.

16. Learn and implement skills to manage thoughts, urges, and physical sensations related to drug use and associated behavior problems (e.g., child neglect); replace these thoughts and actions with those facilitative of prosocial thoughts and actions. (21)

21. Use cognitive therapy and self-control techniques (e.g., identifying thoughts, urges, and emotional-physical sensations associated with drug use); teach thought-stopping, having the client redirect self to alternative, competing thoughts, feelings, and actions (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

17. Learn and implement self-control skills to manage high risk, problem situations within the family. (22)

22. Teach the client self-control strategies through imaginal rehearsal (e.g., scenes in which he/she identifies family-linked triggers to drug use or problem behavior; detects thoughts, feelings, images, and actions; thought-stop; relax; review potential negative consequences; review prosocial alternative actions, etc.); provide feedback, including praise and suggestions for future improvement (see *Family Behavior Therapy* by Donahue and Azrin).

18. Parents learn parenting skills. (23)

23. Teach the parents parenting skills (e.g., attending, reinforcing, praising, tactile reinforcement, pleasant tone, and ignoring undesired behaviors) through role-play with the client; assign homework to practice "catching their children being good" while ignoring undesired behaviors.

19. Learn and implement positive parenting techniques. (24)

20. Family members agree to implement a contingency contract. (25)

21. Learn and implement personal coping skills to manage common day-to-day challenges within the family without the use of substances. (26)

22. Learn and implement assertive communication skills to be used among family members. (27)

23. Learn and implement problem-solving skills for use in approaching family problems. (28)

24. Teach the parents to discipline undesired behaviors by telling the child that the undesired behavior was at least partially a product of the situation, and then instruct the child to practice the desired behavior; assign as homework and review toward improving skills.

25. Help the family develop a positive reinforcement system for performance of behaviors that are incompatible with drug use (e.g., school/work attendance, coming home when expected, doing chores, spending time with parents), with restriction of these reinforcers when drug use occurs (or assign "Using Reinforcement Principles in Parenting" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

26. Assess current skill (e.g., problem solving, relaxation, positive parenting, assertiveness, etc.) in managing common everyday family stressors; use behavioral techniques (e.g., instruction, modeling, role-playing) to build skills to manage these challenges without the use of substances.

27. Using modeling, role-playing, and behavior rehearsal, teach the client and family members assertive communication skills (e.g., call someone; go to a meeting; use "I messages"; simple, empathic, and confrontational assertion; or assign the client to complete the "Communication Skills" exercise from the *Addiction Treatment Homework Planner,* 4th ed. by Finley and Lenz).

28. Using modeling, role-playing, and behavior rehearsal, teach the client and family members a

	problem-solving approach to conceptualizing and addressing problems including defining the problem, generating options, evaluating the pros and cons of each option, developing a plan, implementing, reevaluating, and adapting (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).
24. Learn and implement conflict resolution skills to be used during a family argument. (29, 30)	29. Using modeling, role-playing, and behavior rehearsal, teach the client and family members what to do when he/she is in a family conflict (e.g., call someone; go to a meeting; use "I messages"; accept the responsibility for his/her own behavior, don't blame; turn it over to a higher power; stop, look, listen, think, and plan before acting).
	30. Using modeling, role-playing, and behavior rehearsal, teach the client how to say "no" to alcohol/drugs; practice refusal in several high-risk situations.
25. Learn and implement refusal skill. (30)	30. Using modeling, role-playing, and behavior rehearsal, teach the client how to say "no" to alcohol/drugs; practice refusal in several high-risk situations.
26. Structure time and increase self-esteem by obtaining employment. (31)	31. Refer the client to a supported employment program, or coach the client on preparing for employment, searching for a job, and maintaining employment (see the chapter on Occupational Problems in this *Planner*).
27. Learn and implement financial management skills. (32)	32. Teach financial management skills including learning how to identify if family is in financial deficit or surplus, learning to obtain and

manage additional income, and prioritizing expenses (or assign "Plan a Budget" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

28. Allow home visit to assess family living environment. (33)

33. Tour the family's home to praise efforts to prevent home hazards and maintain a clean, stimulating and well-organized home; assess home health hazards (i.e., toxins, electrical hazards, adequate food/nutrition, maintenance of medical check-ups, etc.), home cleanliness, equipment, and materials facilitating personal and social growth of children (i.e., toys, books, clothing, home decorations); prompt family members to recognize hazards, praise for discovering and implementing solutions, and assist with the generation and implementation of solutions.

29. Plan and implement pleasurable family activities that promote communication and bonding. (34)

34. Assist the family in identifying and planning several pleasurable family activities in which all family members participate such as eating dinner together, going to church together, bowling, bike riding, playing a table game, etc. (or assign "Creating a Family Ritual" in the *Addiction Treatment Homework Planner,* 4th ed. by Finley and Lenz); process the experience and redirect for conflict management.

30. List the ways in which a higher power can assist in recovery from family conflicts and addiction. (35)

35. Teach the client about the 12-step recovery group's concept of a higher power, and how this power can be used to assist in resolving family conflicts and addiction (e.g., attend worship services with family members, pray at meals, have family devotions where the family prays together).

31. Increase the level of independent functioning. (36, 37, 38)

32. Agree to continue to work on family conflict and addiction issues by regularly attending recovery groups and family therapy in aftercare. (39)

33. Complete or give permission to a significant other to complete a re-administration of a survey of the client's family as a means of assessing treatment outcomes. (40)

34. Complete a survey to assess the degree of satisfaction with treatment. (41)

36. Probe the client's fears surrounding emancipation; process these fears to resolution.

37. Confront the client's emotional dependence and his/her avoidance of economic responsibility, which promote a continuing pattern of dependently living off of others.

38. Develop a structured written plan for the client's emancipation that includes steady employment, paying his/her own expenses, and independent housing.

39. Help the client develop an aftercare program that includes regular attendance at recovery groups and the family therapy that is necessary to resolve family conflicts and maintain abstinence from addictive behavior.

40. Assess the outcome of treatment by re-administering to the client or a significant other an objective survey of the client's family conflict; give the client feedback regarding the results of the assessment.

41. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	313.81	Oppositional Defiant Disorder
	312.8	Conduct Disorder
	V61.20	Parent-Child Relational Problem
	V61.1	Partner Relational Problem
	V61.8	Sibling Relational Problem
	V71.01	Adult Antisocial Behavior
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.7	Antisocial Personality Disorder
	301.6	Dependent Personality Disorder
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	_____	_____

GAMBLING

BEHAVIORAL DEFINITIONS

1. Reports a history of repeated unsuccessful attempts to stop or cut down on gambling, despite the verbalized desire to do so and the many negative consequences of continued gambling.
2. Denies that gambling is a problem, despite feedback from significant others that gambling is negatively affecting them and others.
3. Maintains a distorted belief that more gambling will certainly result in a financial windfall.
4. Experiences persistent physical, legal, financial, vocational, social, and/or relationship problems that are directly caused by gambling.
5. Has suspended important social, recreational, and/or occupational activities because they interfere with gambling.
6. Exhibits restlessness and irritability when attempting to stop gambling.
7. Reports frequent loss of time when gambling.
8. Demonstrates physical withdrawal symptoms (e.g., shaking, nausea, headaches, sweating, anxiety, insomnia, and/or depression) when going without gambling for any length of time.
9. Has a history of arrests for gambling-related offenses (e.g., bad checks, forgery, embezzlement, theft).
10. Invests large amounts of money, time, and activities to gamble.
11. Gambles greater amounts of money and for a longer time than intended.
12. Substance abuse accompanies gambling behavior.

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LONG-TERM GOALS

1. Accept the powerlessness and unmanageability over gambling and participate in a recovery-based program.
2. Accept the problem with gambling and begin to actively participate in a recovery program.
3. Withdraw from gambling emotionally and learn a new program of recovery, free from excessive stress and addictive behavior.
4. Acquire the necessary skills to maintain long-term abstinence from gambling.
5. Develop financial planning that will allow repayment of losses and established financial stability.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Provide honest and complete information regarding gambling history. (1)	1. Complete a thorough family and personal biopsychosocial history that has a focus on the client's gambling.
2. Complete psychological testing or objective questionnaires for assessing problem gambling. (2)	2. Administer to the client psychological instruments designed to objectively assess problem gambling (e.g., Maroondah Assessment Profile for Problem Gambling [G-MAP] by Loughman, Pierce, and Sagris-Desmond; South Oaks Gambling Screen [SOGS]; The Addiction Severity Index-Gambling Subscale [ASI-G]); give the client feedback regarding the results of the assessment.
3. Verbalize an increased knowledge of addiction and the process of recovery. (3, 4, 5, 6)	3. Assign the client to attend a gambling didactic series to increase knowledge of the patterns and effects of gambling.

4. Ask the client to identify several key points attained from attending each didactic; process these points.
5. Teach the client about cross-tolerance (i.e., one drug or addictive behavior causes tolerance to develop for another); apply this to the client's situation.
6. Require the client to read the Gambler's Anonymous (GA) *Combo Book* and gather five key points; process the points in session.

4. List 10 negative consequences resulting from or exacerbated by gambling. (7)

7. Ask the client to make a list of the ways gambling has negatively impacted his/her life (or assign *The Gambling Addiction Patient Workbook* by Perkinson); process the list with the therapist or group.

5. Verbally admit to powerlessness over gambling. (8)

8. Assign the client to complete a GA First Step paper admitting to powerlessness over gambling behavior and any other addictions (or assign "Understanding Nonchemical Addictions" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz), and present it in group therapy or to the therapist for feedback.

6. Verbalize a recognition that gambling was used as the primary coping mechanism to escape from stress or emotional pain, and resulted in negative consequences. (9, 10, 11)

9. Assess the client's history for depression, abuse, neglect, or other traumas that contribute to underlying emotional pain.
10. Explore how gambling was used to escape from stress, emotional pain, and/or boredom; highlight the negative consequences of this pattern of escapism.
11. Probe the client's sense of shame, guilt, and low self-worth that has resulted from gambling and its consequences.

7. Develop a list of the social, emotional, and family factors that contributed to gambling. (1, 12)	1. Complete a thorough family and personal biopsychosocial history that has a focus on the client's gambling. 12. Using the biopsychosocial history, assist the client in understanding the familial, emotional, and social factors that contributed to the development of problem gambling.
8. List 10 reasons to work on a plan for recovery from gambling. (13)	13. Assign the client to write a list of 10 reasons to be abstinent from gambling (or assign "What Price Am I Willing to Pay?" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
9. List 10 lies used to hide gambling behavior. (14)	14. Help the client to see the dishonesty that goes along with gambling; have him/her list 10 lies he/she told to hide gambling, teaching the client why honesty is essential to recovery (or assign *The Gambling Addiction Patient Workbook* by Perkinson).
10. Practice turning problems over to a higher power each day. (15, 16)	15. Teach the client about the GA concept of a higher power and how this can assist in recovery. 16. Using a GA Step Three exercise, teach the client about the GA concept of *turning it over*, then assign turning over problems to a higher power each day; have the client record the event and discuss the results (or assign the client to complete the Step Three exercise from the *Gambling Addiction Patient Workbook* by Perkinson).
11. Acknowledge the abuse of mood-altering drugs and/or alcohol and the role substance abuse plays in gambling behavior. (17)	17. Explore the client's use and abuse of mood-altering drugs and alcohol; assess the role of substance abuse in reinforcing gambling behavior.
12. Identify and accept the need for substance abuse treatment. (18)	18. Conduct Motivational Interviewing to assess the client's stage of

	preparation for change; intervene accordingly, moving from building motivation, through strengthening commitment to change, to participation in treatment (see *Problem and Pathological Gambling* by Whelan, Steenbergh, and Meyers).
13. Take prescribed medications as directed by the physician. (19)	19. Refer the client to a physician who will assess for the possible use of psychotropic medication for pathological gambling (e.g., antidepressants), monitor the effectiveness and side effects of medication, and make adjustments as needed.
14. Participate in individual or group therapy sessions focused on recovery from pathological gambling. (20)	20. Refer or conduct individual or group therapy using cognitive behavioral therapy with relapse prevention (see *Understanding and Treating the Pathological Gambler* by Ladouceur et al.; *Pathological Gambling: Etiology, Comorbidity, and Treatment* by Petry; *Problem and Pathological Gambling* by Whelan et al.).
15. Identify realistic goals for substance abuse recovery. (21, 22)	21. Request that the client write out basic treatment expectations (e.g., personal changes, social changes, emotional needs) regarding recovery and process these with the clinician.
	22 Emphasize the goal of recovery despite the client's risk of lapses or relapses.
16. Verbalize a commitment to abstain from the use of mood-altering drugs. (23)	23. Develop an abstinence contract with the client regarding the termination of the use of his/her drug; process the client's feelings related to the commitment.
17. Identify and make changes in social relationships that will support recovery. (24)	24. Review the negative influence of the client continuing his/her gambling-related friendships

	("gambling buddies"), and assist him/her in making a plan to develop new relationships; revisit routinely and facilitate toward development of a new social support system. EBP
EBP 18. Identify projects and other social and recreational activities that sobriety will now afford and that will support sobriety. (25, 26)	25. Assist the client in planning social and recreational activities that are free from association with gambling; revisit routinely and facilitate toward development of a new set of activities. EBP
	26. Plan household, work-related, and/or other free-time projects that can be accomplished to build the client's self-worth and self-concept without the practice of gambling. EBP
EBP 19. Identify the positive impact that sobriety will have on intimate and family relationships. (27)	27. Assist the client in identifying positive changes that will be made in family relationships during recovery. EBP
EBP 20. Identify, challenge, and replace destructive self-talk with positive, strength building self-talk. (28, 29)	28. Use cognitive therapy approaches to explore the client's schema and self-talk that weaken his/her resolve to remain abstinent; challenge the biases; assist him/her in generating realistic self-talk that correct for the biases and build resilience (or assign the client to complete *Overcoming Your Pathological Gambling* by Ladouceur). EBP
	29. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); review and reinforce success. EBP

21. Learn and implement personal coping strategies to manage urges to lapse back into gambling. (30)

30. Teach the client tailored coping strategies involving calming strategies (e.g., relaxation, breathing), thought-stopping, positive self-talk, and attentional focusing skills (e.g., distraction from urges, staying focused on behavioral goals of abstinence) to manage triggered urges to use chemical substances.

22. Participate in gradual repeated exposure to triggers of urges to lapse back into gambling within individual or group therapy sessions and between them; review with group members and therapist. (31, 32)

31. Direct and assist the client in construction of a hierarchy of urge-producing cues to use substances (or assign "Identifying Relapse Triggers and Cues" or "Relapse Prevention Planning" in the *Addiction Treatment Homework Planner,* 4th ed. by Finley and Lenz).

32. Select initial *in vivo* or role-played cue exposures that have a high likelihood of being a successful experience for the client; facilitate coping and cognitive restructuring within and after the exposure; use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate the exposure, review with the client and group members, if done in group.

23. Learn and implement personal skills to manage common day-to-day challenges and build confidence in managing them without the use of gambling. (33, 34)

33. Assess current skill in managing common everyday stressors (e.g., work, social, family role demands); use behavioral techniques (e.g., instruction, modeling, role-playing) to build social and/or communication skills to manage these challenges without the use of substances.

34. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect*

Right by Alberti and Emmons; *Conversationally Speaking* by Garner).

24. Implement relapse prevention strategies for managing possible future situations with high-risk for relapse. (35, 36, 37, 38)

35. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse.

36. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

37. Request that the client identify feelings, behaviors, and situations that place him/her at a higher risk for substance abuse (or assign "Relapse Triggers" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

38. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships (or assign "Aftercare Plan Components" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

25. Family members decrease the frequency of enabling the gambler after verbally identifying their enabling behaviors. (39)

39. Monitor the client's family for enabling behaviors; assist the client's family members in implementing persistent tough-love techniques.

26. Complete a re-administration of objective tests of problem gambling as a means of assessing treatment outcome. (40)

40. Assess the outcome of treatment by re-administering to the client objective tests of problem gambling; evaluate the results and provide feedback to the client.

27. Complete a survey to assess the degree of satisfaction with treatment. (41)

41. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	312.31	Pathological Gambling
	312.30	Impulse-Control Disorder NOS
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	_____	_____
	_____	_____

GRIEF/LOSS UNRESOLVED

BEHAVIORAL DEFINITIONS

1. Presents with unresolved bereavement, intense longing for the significant other, and engaging in addictive behavior to cope with grief.
2. Reports constant thoughts of the lost loved one, to the point of inability to move forward in life.
3. Verbalizes excessive and unreasonable feelings of responsibility for the loss of a significant other, including believing that he/she did not do enough to prevent the person's death.
4. Expresses feelings of guilt about being a survivor when loved ones have died.
5. Lacks ability to talk about the death of a loved one on anything more than a superficial level.
6. Demonstrates vegetative symptoms of depression (e.g., lack of appetite, weight loss, sleep disturbance, anhedonia, lack of energy).
7. Talking or thinking about the deceased loved one results in overwhelming sadness.
8. Has thoughts of suicide to relieve the pain and join the significant other.

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LONG-TERM GOALS

1. Resolve feelings of anger, sadness, guilt, and/or abandonment surrounding the loss of the loved one, and make plans for the future.
2. Accept the loss of the loved one and increase social contact with others.
3. Develop coping skills to help renew old relationships and make new ones.
4. Maintain a program of recovery free from addiction and unresolved grief.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Tell the story of the lost relationship. (1, 2)	1. Encourage the client to share the entire story of the relationship with the lost person, possibly using pictures or mementos connected to the deceased loved one. 2. Ask the client to elaborate in a written autobiography the circumstances, feelings, and effects of the loss or losses in his/her life.
2. Complete psychological testing or objective questionnaires for assessing the depth of grief. (3)	3. Administer to the client psychological instruments designed to objectively assess the depth of grief and depression (e.g., Beck Depression Inventory-II [BDI-II], Grief Experience Inventory [GEI]); give the client feedback regarding the results of the assessment.
3. Discuss the positive and negative aspects of the lost relationship. (4)	4. Help the client to see both the positive and negative aspects of the lost relationship, keeping him/her from over-idealizing the relationship.

4. Read books on the topic of grief to better understand the loss experience and to increase a sense of hope. (5, 6)	5. Ask the client to read books on grief and loss (e.g., *Getting to the Other Side of Grief: Overcoming the Loss of a Spouse* by Zonnebelt-Smeenge and DeVries; *How Can It Be All Right When Everything Is All Wrong?* by Smedes; *How to Survive the Loss of a Love* by Colgrove, Bloomfield, and McWilliams; *When Bad Things Happen to Good People* by Kushner); process the content.
	6. Ask the parents of a deceased child to read a book on coping with their loss (e.g., *The Bereaved Parent* by Schiff); process the key themes gleaned from the reading.
5. Identify what stages of grief have been experienced along the continuum of the grieving process. (7, 8)	7. Educate the client on the stages of the grieving process and answer any questions he/she may have.
	8. Assist the client in identifying the stages of grief that he/she has experienced and which stage he/she is presently working through.
6. Verbalize the feelings of anger, guilt, sadness, and/or abandonment felt because of the loss. (9)	9. Help the client to identify the feelings of hurt, loss, abandonment, and anger felt because of the loss; trace and resolve the cause of these strong feelings.
7. Verbalize how the loss of the loved one led to addiction in order to avoid painful feelings. (10, 11)	10. Teach the client how the loss of the loved one led to addiction so as to cope with the pain.
	11. Teach the client how chemical use has led to an avoidance of working through the loss.
8. List five negative consequences that resulted from using addiction to cope with grief and loss. (12)	12. Assist the client in identifying how addiction has led to more pain and unresolved feelings.
9. Verbalize a resolution of guilt about the loss. (13, 14)	13. Explore the client's feelings of guilt and blame surrounding the

loss (or assign the client to read *Good Grief* by Westberg).

14. Using logic and reasoning, help the client to see that he/she is not responsible for the loss.

10. Terminate the blame of others for the loss. (15)

15. Teach the client about the destructive consequences of holding on to anger and blaming others for the loss.

11. Verbalize an understanding of how dependence on the lost person and dependence on addictive behavior are similar. (16)

16. Help the client to see the common elements in the dependency on the deceased individual and on addictive behavior.

12. Express thoughts and feelings about the deceased that went unexpressed while the deceased was alive. (17, 18, 19, 20)

17. Conduct an empty chair exercise with the client, where he/she focuses on expressing to the lost loved one, imagined in the chair, what he/she never said while that loved one was alive.

18. Assign the client to visit the grave of the loved one to "talk to" the deceased and ventilate his/her feelings.

19. Ask the client to write a letter to the lost person describing his/her fond memories, painful and/or regretful memories, and how he/she currently feels (or assign "Dear _____: A Letter to a Lost Loved One" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); process the letter in session.

20. Assign the client to write to the deceased loved one, with a special focus on his/her feelings associated with the last meaningful contact with that person (or assign "Am I Having Difficulty Letting Go?" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

13. Make a written plan to increase independence and social interaction. (21, 22, 23)

21. Help the client make a written plan to help him/her live a more active and independent life (e.g., make plans for social life, hobbies, financial security, job, recovery, contact sponsor, a grief group, a singles' group).

22. Assign the client to write a plan to improve social contact with old friends and to make new ones (or assign "Moving On with My Life" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

23. Teach the client about the importance of regularly attending recovery groups, getting a sponsor, and helping others in recovery.

14. Attend a grief/loss support group. (24)

24. Ask the client to attend a grief/loss support group and report to the therapist how he/she felt about attending.

15. List ways in which a higher power can assist in recovery from grief and addiction. (25, 26, 27)

25. Teach the client about the 12-step recovery program's concept of a higher power, and help him/her to see how this can assist in recovery from grief and addiction (e.g., talk to the higher power about the grief/loss, imagine the higher power healing the pain, ask the higher power to direct you to other friends and family who can provide support).

26. Assign the client to read page 449 in the Alcoholics Anonymous *Big Book*, and discuss how the loss of a loved one could be a part of the higher power's plan.

27. Using a 12-step recovery program's Step Eleven exercise, teach the client how to pray and meditate; then assign the client to contact his/her higher power each day about his/her grief.

16. Write a letter of goodbye to the lost loved one, sharing feelings and thoughts. (9, 13, 28)

17. Make contact with a 12-step recovery program temporary sponsor and share plans for recovery. (23, 29)

18. Identify the positive characteristics of the deceased loved one, the positive aspects of the relationship with the deceased loved one, and how these things may be remembered. (30, 31)

19. Encourage at least one person in recovery each day. (32)

20. Develop a written aftercare plan to resolve addiction and grief. (33)

9. Help the client to identify the feelings of hurt, loss, abandonment, and anger felt because of the loss; trace and resolve the cause of these strong feelings.

13. Explore the client's feelings of guilt and blame surrounding the loss (or assign the client to read *Good Grief* by Westberg).

28. Assign the client to write a letter to the lost individual, sharing the unresolved feelings; process the letter in group or individual session.

23. Teach the client about the importance of regularly attending recovery groups, getting a sponsor, and helping others in recovery.

29. Assign the client to make contact with a 12-step recovery program's temporary sponsor and discuss recovery plans.

30. Ask the client to list the most positive aspects of and memories about his/her relationship with the lost loved one.

31. Assist the client in developing rituals (e.g., placing memoriam in newspaper on anniversary of death, volunteering time to a favorite cause of the deceased person) that will celebrate the memorable aspects of the loved one and his/her life.

32. To improve self-worth and self-esteem, assign the client to encourage one person in recovery each day.

33. Help the client to develop a written aftercare plan that specifically outlines a recovery plan such as attending 12-step recovery

	program meetings, aftercare sessions, continued therapy, contacting sponsor, turning it over daily, prayer and meditation (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
21. Family members verbalize a connection between unresolved grief/loss and addictive behavior. (34, 35)	34. Discuss with family members the connection between grief and addictive behavior. 35. In a family session, review what each member can do to assist the client in recovery.
22. Complete a re-administration of objective tests of depth of grief and depression as a means of assessing treatment outcome. (36)	36. Assess the outcome of treatment by re-administering to the client objective tests of depth of grief and depression; evaluate the results and provide feedback to the client.
23. Complete a survey to assess the degree of satisfaction with treatment. (37)	37. Administer a survey to assess the client's degree of satisfaction with treatment.
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DIAGNOSTIC SUGGESTIONS

Axis I:	296.2x	Major Depressive Disorder, Single Episode
	296.3x	Major Depressive Disorder, Recurrent
	311	Depressive Disorder NOS
	308.3	Acute Stress Disorder
	V62.82	Bereavement
	309.0	Adjustment Disorder with Depressed Mood
	309.3	Adjustment Disorder with Disturbance of Conduct
	309.28	Adjustment Disorder with Mixed Anxiety and Depressed Mood
	309.4	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
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IMPULSIVITY

BEHAVIORAL DEFINITIONS

1. Exhibits a tendency to act too quickly on impulses without careful thought or planning, resulting in numerous negative consequences.
2. Demonstrates difficulty with patience, particularly while waiting for someone or waiting in line.
3. Impulsivity facilitates a self-defeating pattern of addiction behavior.
4. Reports loss of control over aggressive impulses, resulting in assault, self-destructive behavior, and/or damage to property.
5. Desires everything immediately—demonstrates a decreased ability to delay pleasure or gratification.
6. Has a history of acting out in at least two areas that are potentially self-damaging, (e.g., spending money, sexual activity, reckless driving, addiction).
7. Overreacts to mildly aversive or pleasure-oriented stimulation.
8. Experiences a sense of tension or affective arousal before engaging in the impulsive behavior (e.g., kleptomania or pyromania).
9. Senses pleasure, gratification, or release at the time of committing an antisocial act.

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LONG-TERM GOALS

1. Maintain a program of recovery, free from impulsive behavior and addiction.
2. Reduce the frequency of impulsive behavior and increase the frequency of behavior that is carefully thought out.
3. Learn the techniques necessary to decrease impulsive thoughts, feelings, and behaviors, and develop a program of recovery consistent with thoughtful behavior and abstinence.
4. Learn to stop, think, and plan before acting.
5. Decrease antisocial behaviors and practice prosocial behaviors.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Verbalize an understanding of the powerlessness and unmanageability that results from impulsivity and addiction. (1)	1. Help the client to understand how impulsivity and addictive behavior led to powerlessness and unmanageability (or assign the Step One exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
2. Verbalize specific instances of the negative consequences of impulsivity and addiction. (2)	2. Review the client's behavior pattern to assist him/her in clearly identifying, without minimization, denial, or projection of blame, his/her pattern of impulsivity (or assign "Impulsive Behavior Journal" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
3. Complete psychological testing or objective questionnaires for assessing impulsivity. (3)	3. Administer to the client psychological instruments designed to objectively assess impulsivity (e.g., Barratt Impulsiveness Scale [BIS],

	Conners' Adult ADHD Rating Scales [CARRS]); give the client feedback regarding the results of the assessment.
4. Discuss how impulsivity and addiction meet the 12-step recovery program's criteria for *insanity*. (4)	4. Help the client to see that doing the same things over and over again and expecting different results meets the 12-step recovery program's definition of *insanity* (or assign the Step Two exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
5. List the negative consequences that are caused by impulsivity. (5, 6, 7)	5. Assist the client in making connections between his/her impulsivity and the negative consequences for himself/herself and others resulting from it.
	6. Assign the client to write a list of negative consequences that occurred because of impulsivity (or assign "Recognizing the Negative Consequences of Impulsive Behavior" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
	7. Help the client to see how dangerous it is to act impulsively (e.g., you don't have time to think, you can't plan effectively).
6. Verbally identify several times when impulsive action led to addictive behavior and subsequent negative consequences. (8)	8. Explore times when the client acted too quickly on impulses, resulting in addictive behavior.
7. Increase the frequency of reviewing behavioral decisions with a trusted friend or family member for feedback regarding consequences before the decision is enacted. (9, 10)	9. Conduct a session with spouse, significant other, sponsor, or family member and client to develop constructive advice prior to his/her engaging in impulsive acts.
	10. Review the client's implementation of reviewing with significant others decisions to act before engaging in impulsive

	actions; reinforce success and redirect for failure.
8. Verbalize the biopsychosocial elements that cause or exacerbate impulsivity and addictive behavior. (11)	11. Probe the client's biopsychosocial history and help the client to see the contributing factors to his/her impulsivity and addictive behavior (e.g., family models of impulsivity or addictive behavior, anxiety that energizes impulsivity, failure to learn delay of gratification in childhood) (or assign "Understanding Family History" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
9. Comply with a physician's evaluation regarding the necessity for psychopharmacological intervention. (12)	12. Refer the client to a physician to examine him/her, order medications as indicated, titrate medications, and monitor for side effects and effectiveness.
10. Take all medications as prescribed and report as to effectiveness and side effects. (13, 14)	13. Direct the staff to administer the medications as ordered by the physician.
	14. Monitor the client's psychotropic medication for effectiveness as well as side effects.
11. Identify the thoughts that trigger impulsive behavior, and then replace each thought with a thought that is more accurate. (15, 16)	15. Help the client to uncover dysfunctional thoughts that lead to impulsivity; assist him/her in replacing each dysfunctional thought with a thought that is more accurate, positive, self-enhancing and adaptive (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
	16. Help the client to develop a list of positive, accurate, self-enhancing thoughts to read to himself/herself each day, particularly when feeling upset, anxious, or uncomfortable (or assign "Positive Self-Talk" in the *Adult Psychotherapy Home-*

	work Planner, 2nd ed. by Jongsma).
12. List the impulsive behaviors that are displayed when feeling anxious and uncomfortable, and replace each behavior with an action that is positive and adaptive. (2, 17)	2. Review the client's behavior pattern to assist him/her in clearly identifying, without minimization, denial, or projection of blame, his/her pattern of impulsivity (or assign "Impulsive Behavior Journal" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
	17. Probe the client's anxious, impulsive behaviors, and then use modeling, role-playing, and behavior rehearsal to teach him/her new behaviors that are positive and adaptive such as talking to someone about the problem, taking a time out, calling the sponsor, going to a meeting, exercising, or relaxing (or assign "A Different Approach" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
13. Implement relaxation procedures when feeling upset or uncomfortable. (18)	18. Teach the client relaxation techniques (e.g., progressive relaxation, self-hypnosis, biofeedback); assign him/her to relax whenever he/she feels uncomfortable (or assign the "Learning to Self-Soothe" exercise from the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
14. Practice stopping, looking, listening, thinking, and planning before acting. (19, 20)	19. Using modeling, role-playing, and behavior rehearsal, show the client how to use "stop, look, listen, think, and plan before acting" in various current situations (or assign "Problem Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

	20. Review the client's use of "stop, look, listen, think, and plan" in day-to-day living, and identify the positive consequences.
15. Verbalize an understanding of a 12-step recovery program's Step Three regarding the role of a higher power, and how this step can be used in recovery from impulsivity and addiction. (21, 22)	21. Teach the client about the 12-step recovery program's concept of a higher power, and discuss how he/she can use a higher power effectively in recovery (e.g., practice stopping and asking a higher power for strength and direction, practice daily prayer and meditation).
	22. Teach the client how to turn his/her will and life over to the care of a higher power (or assign the Step Three exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
16. Relate how each wrong behavior identified in a 12-step recovery program's Step Four exercise can be related to impulsivity and addiction. (23, 24)	23. Using a 12-step recovery program's Step Four exercise, assign the client to write an autobiography of the exact nature of his/her wrongs, and relate these wrongs to impulsivity and addictive behavior.
	24. Assist the client in acknowledging the relationship between the wrongful behaviors identified in a Step Four exercise and his/her impulsivity and addictive behavior.
17. Develop and write a continuing care program that includes the recovery group meetings and any further therapy that is necessary for recovery. (25)	25. Help the client to develop an aftercare plan that includes regular recovery groups, getting a sponsor, and any further therapy necessary to recover from impulsivity and addiction.
18. Family members verbalize a connection between impulsivity and addictive behavior. (26, 27, 28)	26. Encourage the client to share with family members the journey through impulsivity, addiction, and recovery.

27. Discuss with family members the connection between impulsive behavior and addictive behavior.

28. In a family session, review what each member can do to assist the client in recovery.

19. Complete a re-administration of objective tests of impulsivity as a means of assessing treatment outcome. (29)

29. Assess the outcome of treatment by re-administering to the client objective tests of impulsivity; evaluate the results and provide feedback to the client.

20. Complete a survey to assess the degree of satisfaction with treatment. (30)

30. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	312.8	Conduct Disorder
	313.81	Oppositional Defiant Disorder
	296.4x	Bipolar I Disorder, Most Recent Episode Manic
	301.13	Cyclothymic Disorder
	296.89	Bipolar II Disorder
	312.34	Intermittent Explosive Disorder
	314	Attention-Deficit/Hyperactivity Disorder
	321.30	Impulse-Control Disorder NOS
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Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
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LEGAL PROBLEMS

BEHAVIORAL DEFINITIONS

1. Presents with legal charges pending adjudication.
2. Has a history of repeated violations of the law, many occurring while under the influence of drugs or alcohol.
3. Unresolved legal problems are complicating recovery from addiction.
4. Expresses fear of the legal system adjudicating current problems.
5. Has a history of repeated violations of the law related to buying, selling, or using illegal substances.
6. Is under a court order to seek treatment for addiction.
7. Expresses feelings of anger, resentment, and fear of abandonment associated with impending divorce.
8. Chemical dependency has resulted in several arrests.
9. Fears loss of freedom due to current legal charges.

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LONG-TERM GOALS

1. Maintain a program of recovery free from addiction and legal conflicts.
2. Accept the responsibility for legal problems without blaming others.
3. Consult with legal authorities (e.g., attorney, probation officer, police, court official) to make plans for adjudicating legal conflicts.
4. Understand the need to maintain abstinence to remain free of negative consequences, which include legal problems.

5. Decrease antisocial behaviors and increase prosocial behaviors.

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SHORT-TERM OBJECTIVES

1. Verbalize the powerlessness and unmanageability that results from legal conflicts and addiction. (1)

2. Identify the nature and history of legal problems. (2)

3. Complete psychological testing or objective questionnaires for assessing antisocial traits and propensity for illegal behavior. (3)

4. Verbalize an acceptance of the responsibility for addiction and legal problems without blaming others. (4, 5)

THERAPEUTIC INTERVENTIONS

1. Help the client to understand the relationship between addictive behavior and legal conflicts, and how these problems result in powerlessness and unmanageability.

2. Gather a history of the client's illegal behavior and his/her experience with the legal system.

3. Administer to the client psychological instruments designed to objectively assess antisocial traits and propensity for illegal behavior (e.g., Millon Clinical Multiaxial Inventory-III [MCMI-III], Jesness Behavior Checklist); give the client feedback regarding the results of the assessment.

4. Help the client to identify and accept responsibility for the many decisions that he/she made that resulted in addiction and legal problems without blaming others (or assign "Handling Tough Situations in a Healthy Way" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

5. Confront the client for avoidance of his/her responsibility for legal

	problems (or assign "Accept Responsibility for Illegal Behavior" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
5. Acknowledge the connection between legal problems and addictive behavior. (6, 7)	6. Teach the client the relationship between his/her legal problems and his/her addictive behavior (or assign "What's Addiction Got to Do with My Problems?" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz); solicit the client's acknowledgement of this relationship.
	7. Assign the client to write how each legal conflict has been related to addictive behavior.
6. Write a plan that outlines the changes needed in behavior, attitude, and associates to protect self from harmful legal consequences. (8)	8. Teach the client the difference between antisocial and prosocial behaviors, helping to identify his/her antisocial behaviors and attitudes; help develop prosocial plans for changes to be made in recovery (e.g., respect for the law, helping others, honesty, reliability, regular attendance at work, recovery groups, aftercare, halfway house).
7. Replace inaccurate self-defeating thoughts with realistic, positive cognitions. (9, 10)	9. Probe the client's inaccurate self-defeating thoughts and feelings that surround addictive behavior and legal problems.
	10. Assist the client in identifying positive, realistic thoughts to replace dysfunctional thinking that leads to addictive and illegal behaviors (or assign "Crooked Thinking Leads to Crooked Behavior" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
8. Meet with an attorney to make plans for resolving legal conflicts. (11)	11. Encourage and facilitate the client to meet with an attorney to discuss plans for resolving legal conflicts.

9. Contact the probation or parole officer and agree in writing to meet the conditions of probation or parole. (12)	12. Encourage and facilitate the client to meet with his/her probation or parole officer, and assign him/her to agree in writing to meet all conditions of probation or parole.
10. Verbalize ways to meet social, emotional, and financial needs in recovery without illegal activity or addiction. (13)	13. Help the client to develop a plan to meet social, emotional, and financial needs in recovery without resorting to criminal activity or addictive behavior.
11. Verbalize the importance of obeying the laws of society to maintain abstinence and work a program of recovery. (8, 14)	8. Teach the client the difference between antisocial and prosocial behaviors, helping to identify his/her antisocial behaviors and attitudes; help develop prosocial plans for changes to be made in recovery (e.g., respect for the law, helping others, honesty, reliability, regular attendance at work, recovery groups, aftercare, halfway house).
	14. Help the client to understand why he/she needs to obey the law in order to maintain abstinence from addictive behavior.
12. Identify and replace the criminal thinking that led to legal conflicts and addiction. (15, 16)	15. Teach the client about criminal thinking (e.g., rationalization, denial, super-optimism, blaming others); assist him/her in identifying his/her criminal thinking, correcting each criminal thought with a thought that is honest and respectful of others.
	16. Help the client to understand the importance of helping others in recovery in order to replace a criminal attitude of taking and entitlement with an attitude of giving and self-sacrifice.
13. Verbalize the importance of a higher power in recovery, and list five ways in which a higher power can assist in recovery. (17)	17. Teach the client about the 12-step recovery program's concept of a higher power and how a higher power can assist in recovery from

	legal conflicts and addiction (e.g., practice trusting a higher power to help with legal problems, practice daily prayer and meditation).
14. Develop an aftercare program that includes regular attendance at recovery groups and any other necessary therapy. (18)	18. Help the client to develop an aftercare program that has all of the elements necessary to maintain abstinence and resolve legal conflicts (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
15. Verbalize the importance of resolving legal issues honestly. (19)	19. Help the client to understand the importance of resolving legal conflicts honestly and legally; teach that honesty is the basis for trust.
16. Family members verbalize what each can do to assist the client in recovery. (20, 21)	20. Discuss with family members the connection between legal problems and addictive behavior. 21. In a family session, review what each member can do to assist the client in recovery.
17. Complete a re-administration of objective tests of legal problems and antisocial behavior as a means of assessing treatment outcome. (22)	22. Assess the outcome of treatment by re-administering to the client objective tests of antisocial traits and propensity for illegal behavior; evaluate the results and provide feedback to the client.
18. Complete a survey to assess the degree of satisfaction with treatment. (23)	23. Administer a survey to assess the client's degree of satisfaction with treatment.
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DIAGNOSTIC SUGGESTIONS

Axis I:	312.8	Conduct Disorder
	313.81	Oppositional Defiant Disorder
	309.3	Adjustment Disorder with Disturbance of Conduct
	312.34	Intermittent Explosive Disorder
	V71.01	Adult Antisocial Behavior
	_____	_____
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Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
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LIVING ENVIRONMENT DEFICIENCY

BEHAVIORAL DEFINITIONS

1. Lives in an environment in which there is a high risk for relapse.
2. Lives with an individual who is a regular user/abuser of alcohol and/or drugs.
3. Experiencing significant social isolation, withdrawal from social life.
4. Lives in an environment in which there is a high risk of physical, sexual, or emotional abuse.
5. Has many friends or relatives who are criminal or addicted.
6. Reports that family is angry or negative toward the addict and not supportive of a recovery program.
7. Presents as financially destitute and in need of assistance for adequate food and shelter.
8. Associates with peer group members who are regular users/abusers of alcohol and/or drugs.
9. Lives in a neighborhood that has a high incidence of alcohol and drug addiction, as well as crime.

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LONG-TERM GOALS

1. Maintain a program of recovery free from addiction and the negative impact of the deficient environment.
2. Improve the social, occupational, financial, and living situation sufficiently to increase the probability of a successful recovery from addiction.
3. Understand the negative impact of the current environment on addiction recovery.
4. Develop a peer group that is supportive of recovery.
5. Family members support the client's recovery.
6. Accept the importance of working a program of recovery that necessitates attendance at recovery groups and helping others.

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SHORT-TERM OBJECTIVES

1. Verbalize the sense of powerlessness and unmanageability that results from a deficient environment and addiction. (1)

2. Identify specific living environment problems and how they negatively affect recovery. (2, 3)

THERAPEUTIC INTERVENTIONS

1. Help the client to see the powerlessness and unmanageability that results from addiction and a deficient environment (or assign the Step One exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Help the client identify problems with his/her living environment and the negative impact that they have on recovery.

3. Help the client to list specific instances when the high-risk social and/or family environment led to negative consequences and addiction (or assign the "Understanding Family History" exercise from the *Addiction Treatment*

	Homework Planner, 4th ed. by Finley and Lenz).
3. Complete psychological testing or objective questionnaires for assessing perception of social and family environment. (4)	4. Administer to the client psychological instruments designed to objectively assess the client's perception of his/her social and family environment (e.g., Quality of Life Inventory [QOLI] by Frish, Family Environment Scale [FES] by Moos and Moos); give the client feedback regarding the results of the assessment.
4. Make a written plan to address each living environment problem in recovery. (5)	5. Help the client to develop a written plan for addressing each living environment problem in recovery.
5. List the positive and negative consequences of continuing to living in the current high-risk environment. (6)	6. Discuss the alternatives that are available for moving out of the current living situation, which promotes ongoing addiction.
6. Identify current social, occupational, and financial needs, and make a plan to meet each need in recovery. (7, 8)	7. Help the client to identify his/her social, occupational, and financial needs, and make a written plan to meet each need in recovery (or assign "Assessing My Needs" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
	8. Teach the importance of a supportive peer group, and assign the client to list 10 reasons why he/she needs a new peer group to maintain abstinence.
7. Write a personal recovery plan detailing the recovery groups, aftercare, social relationships, and further treatment that will be needed in recovery. (9, 10, 11, 12)	9. Facilitate the client meeting with a 12-step recovery program contact person, and encourage him/her to discuss recovery plans.
	10. Help the client to develop a personal recovery plan that has all of the elements necessary to recover from addictive behavior and the deficient living environment (or assign "What Would My Ideal Life Look Like?"

	in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
	11. Encourage the client's attendance at 12-step recovery program meetings as a means of developing a supportive peer group.
	12. Assign the client to write at least five steps that he/she will take to initiate new relationships with recovering people.
8. Implement turning over to a higher power the living environmental problems and the urge to engage in addictive behavior. (13, 14, 15)	13. Teach the client about the 12-step recovery program's concept of a higher power, and show him/her how a higher power can assist in recovery (e.g., by learning how to turn problems over to a higher power, practicing regular prayer and meditation).
	14. Using a 12-step recovery program's Step Three exercise, teach the client how to turn his/her will and life over to a higher power (or assign the client to complete the Step Two and Step Three exercises in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
	15. Monitor the client's implementation of a 12-step recovery program's Step Three exercise; reinforce his/her success and redirect for failure.
9. Verbalize a plan to continue spiritual growth within a community of believers. (16)	16. Assist the client in developing a plan to continue his/her spiritual growth (e.g., church, recovery groups, counseling, meeting with a pastor, spiritual reading material).
10. Practice saying no to addictive and antisocial behavior in high-risk situations. (17, 18, 19, 20)	17. Using modeling, role-playing, and behavior rehearsal, teach the client refusal to engage in addictive behavior, then practice refusal in the high-risk situations for relapse

(e.g., negative emotions, social pressure, interpersonal conflict, positive emotions, and testing personal control).

18. Using a 12-step recovery program's Step Four inventory, assign the client to write an autobiography detailing the exact nature of his/her wrongs, and how these relate to the negative peer group and addictive behavior.
19. Clarify the distinction between passive, aggressive, and assertive behavior.
20. Have the client role-play assertive responses to situations he/she is currently facing in his/her life; assign the client to practice assertive expression of feelings, thoughts, and desires to others during the week.

11. Write a letter to each significant other, discussing problems with the living environment, and share plans for recovery. (21, 22)

21. Help the client to write a letter to each significant other sharing his/her problem with addiction, how the living environment has fostered the addiction, and the plan for recovery.
22. Meet with family members to teach them about addiction, discuss the living environment deficiencies, and make plans for support of the client's recovery.

12. Develop a written plan as to how to react to family members who are addicted. (20, 23)

20. Have the client role-play assertive responses to situations he/she is currently facing in his/her life; assign the client to practice assertive expression of feelings, thoughts, and desires to others during the week.
23 Help the client to develop a plan as to how to deal with family members who are addicted.

13. Family members verbalize what each can do to assist the client in recovery. (24, 25)

14. Complete a re-administration of objective tests of perception of social and family environment as a means of assessing treatment outcome. (26)

15. Complete a survey to assess the degree of satisfaction with treatment. (27)

24. Discuss with family members the connection between living environment deficiencies and addictive behavior.

25. In a family session, review what each member can do to assist the client in recovery.

26. Assess the outcome of treatment by re-administering to the client objective tests of the client's perception of his/her social and family environment; evaluate the results and provide feedback to the client.

27. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	V61.20	Parent-Child Relational Problem
	V61.1	Partner Relational Problem
	V61.8	Sibling Relational Problem
	V62.81	Relational Problem NOS
	V61.21	Physical Abuse of Child
	V61.21	Sexual Abuse of Child
	V61.21	Neglect of Child
	V61.10	Physical Abuse of Adult
	V61.10	Sexual Abuse of Adult
	V62.20	Occupational Problem
	995.54	Physical Abuse of Child (focus on victim)
	995.5	Neglect of Child (focus on victim)
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MANIA/HYPOMANIA

BEHAVIORAL DEFINITIONS

1. Experiences a distinct period of persistently elevated or irritable mood lasting at least four days.
2. Has an inflated sense of self-esteem and an exaggerated, euphoric belief in capabilities that denies any self-limitations or realistic obstacles, but sees others as standing in the way.
3. Reports decreased need for sleep.
4. Is more talkative than normal—pressured speech.
5. Experiences racing thoughts.
6. Has short attention span and is susceptible to distraction.
7. Initiates projects at home, work, or school, but without completion of tasks.
8. Engages in impulsive activities that are potentially self-damaging (e.g., buying sprees, sexual acting out, foolish business investments).
9. Impulsively uses drugs or alcohol without regard to the negative consequences.
10. Demonstrates verbal and/or physical aggression coupled with tantrum-like behavior (e.g., breaking things explosively) if wishes are blocked, which is in contrast to an earlier pattern of restraint.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of manic/hypomanic behavior and addiction.
2. Increase control over impulses, reduce energy level, and stabilize mood.
3. Reduce agitation, irritability, and pressured speech, while increasing rational thinking and behavior.
4. Understand the biopsychosocial aspects of manic/hypomanic states and addiction, and accept the need for continued treatment, including medication.
5. Understand the relationship between manic/hypomanic states and addiction.
6. Terminate addiction and take medications for mania on a consistent basis.

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SHORT-TERM OBJECTIVES

1. Verbalize an acceptance of the sense of powerlessness and unmanageability that results from mania/hypomania and using addiction to cope with impulsivity and mood swings. (1)

2. Identify manic behavior patterns and list several specific instances in which manic/hypomanic states led to addiction. (2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Using a 12-step recovery program's Step One exercise, help the client to see the powerlessness and unmanageability that result from mania/hypomania and the use of addictive behavior to cope with these symptoms.

2. Teach the client about the signs and symptoms of mania/hypomania, and how it can foster addictive behavior (or assign "Early Warning Signs of Mania/ Hypomania" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

3. Assess the client's pattern of manic/hypomanic behavior.

4. Assess the client's addictive behavior history, and identify

	instances in which manic/hypomanic states led to addictive behavior (or assign "Coping with Addiction and Mood Disorders" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
3. Complete psychological testing or objective questionnaires for assessing mania/hypomania. (5)	5. Administer to the client psychological instruments designed to objectively assess mania/hypomania (e.g., Minnesota Multiphasic Personality Inventory-2 [MMPI-2], Personality Assessment Inventory [PAI] by Morey); give the client feedback regarding the results of the assessment.
4. Turn over at least one problem to a higher power each day. (6, 7, 8)	6. Teach the client about the 12-step recovery program's concept of a higher power, and how a higher power can help restore him/her to sanity (e.g., attend worship services and practice daily prayer and meditation).
	7. Using a 12-step recovery program's Step Three exercise, teach the client how to turn problems over to a higher power.
	8. Assign the client to turn over one problem each day to a higher power; review the client's implementation, reinforcing success and redirecting for failure.
5. Agree to placement in an environment that ensures safety to self and others. (9, 10)	9. Perform an assessment of the client's ability to remain safe in the community, including level of manic behavior, impulsivity, natural and programmatic supports, and access to potentially unsafe situations.
	10. Arrange for admission into a crisis residential unit or psychiatric hospital if the client is judged to be

	at imminent risk of harm to himself/herself or to others.
6. Cooperate with psychiatric evaluation as to the need for medication and/or hospitalization to stabilize mood and energy. (11, 12)	11. Arrange for a psychiatric evaluation of the client for pharmacotherapy (e.g., lithium carbonate, Depakote, Lamictil, etc.). EBT 12. Monitor the client's reaction to the psychotropic medication and intervene accordingly (e.g., compliance, side effects, and effectiveness). EBT
7. Achieve a level of symptom stability that allows for meaningful participation in psychotherapy. (13)	13. Monitor the client's symptom improvement toward stabilization sufficient to allow participation in psychotherapy. EBT
8. Participate in family therapy or individual therapy, if family is unavailable. (14)	14. Conduct family-focused treatment with the client and significant others, or adapt the model to individual therapy if family therapy is not possible (see *Bipolar Disorder: A Family Focused Approach* by Miklowitz and Goldstein). EBT
9. Complete psychological testing to assess communication patterns within the family or with significant others. (15)	15. Arrange for the administration of an objective assessment instrument for evaluating communication patterns with family/significant others, particularly expressed emotion (e.g., *Perceived Criticism Scale* by Hooley and Teasdale); evaluate results and process feedback with the client and family. EBT
10. Verbalize an understanding of the causes for, symptoms of, and treatment of manic, hypomanic, mixed, and/or depressive episodes. (16, 17, 18)	16. Teach the client, family, and relevant others, using all modalities necessary, about the signs, symptoms, and phasic relapsing nature of the client's mood episodes; destigmatize and normalize (or assign the client to complete *Managing Bipolar Disorder* by Otto). EBT

17. Teach the client a stress diathesis model of bipolar disorder that emphasizes the strong role of a biological predisposition to mood episodes that is vulnerable to stresses that are manageable.

18. Provide the client with a rationale for treatment involving ongoing medication and psychosocial treatment to recognize, manage, and reduce biological and psychological vulnerabilities that could precipitate relapse.

11. Identify and manage sources of stress that increase the risk of relapse. (19)

19. Identify the client's sources of stress/triggers of potential relapse (e.g., negative events, cognitive interpretations, aversive communication, poor sleep hygiene, medication noncompliance); use cognitive and behavioral techniques to address as needed (e.g., *Cognitive-Behavioral Therapy for the Management of Bipolar Disorder* by Otto and Reilly-Harrington).

12. Verbalize acceptance of the need to take psychotropic medication and commit to prescription compliance with blood level monitoring. (20, 21, 22)

20. Use motivational approaches (e.g., *Enhancing Motivation for Treatment and Change* by Yahne and Miller) to enhance engagement in medication use and compliance; teach him/her the risk for relapse when medication is discontinued, and work toward a commitment to prescription adherence.

21. Assess factors (e.g., thoughts, feelings, stressors) that have precipitated the client's prescription noncompliance (or assign "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); develop a plan for recognizing and addressing them.

13. Implement good sleep hygiene. (23)

14. Develop a "relapse drill" in which roles, responsibilities, and a course of actions is agreed upon in the event that signs of relapse emerge. (24, 25)

15. The client and family commit to replacing aversive communication with positive, honest, and respectful communication. (26, 27, 28)

22. Educate and encourage the client to stay compliant with necessary labs involved in regulating his/her medication levels.

23. Teach the client about the importance of good sleep hygiene; assess and intervene accordingly (see the chapter on Sleep Disturbance in this *Planner*).

24. Educate the client and family about the client's signs and symptoms of pending relapse.

25. Help the client and family draw up a relapse drill detailing roles and responsibilities (e.g., who will call a meeting of the family to problem solve potential relapse; who will call physician, schedule a serum level to be taken, or emergency services, if needed); problem-solve obstacles and work toward a commitment to adherence with the plan.

26. Assess and educate the client and family about the role of aversive communication (e.g., high expressed emotion) in family distress and risk for the client's manic relapse.

27. Use behavioral techniques (education, modeling, role playing, corrective feedback, and positive reinforcement) to teach communication skills including offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner.

28. Assign the client and family homework exercises to use and record use of newly learned communication skills; process results in session.

16. Maintain a reality-based orientation. (29)

17. Terminate self-destructive behaviors such as promiscuity, substance abuse, and the expression of overt hostility or aggression. (30, 31, 32, 33)

18. Client and family implement a problem-solving approach to addressing current conflicts. (34, 35, 36)

29. Use cognitive therapy approaches to help the client differentiate between real and imagined, actual and exaggerated losses, abilities, expectations, and the like (e.g., *Cognitive-Behavioral Therapy for the Management of Bipolar Disorder* by Otto and Reilly-Harrington).

30. Confront the client's grandiosity and demandingness gradually, but firmly.

31. Refocus the client consistently on the effects of his/her actions, emphasizing the impulsive nature of manic/hypomanic episodes and his/her need to identify these symptoms as early as possible (or assign "Recognizing the Negative Consequences of Impulsive Behavior" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

32. Increase the client's sensitivity to the effects of his/her behavior through the use of role-playing, role reversal, and behavioral rehearsal.

33. Identify and confront unhealthy, impulsive, or manic behaviors that occur during contacts with the clinician, enforcing clear rules and roles in the relationship, as well as immediate, short-term consequences for breaking such boundaries.

34. Assist the client and family in identifying conflicts that can be addressed with problem-solving techniques.

35. Use behavioral techniques (education, modeling, role playing, corrective feedback, and positive

reinforcement) to teach the client and family problem-solving skills including defining the problem constructively and specifically, brainstorming options, evaluating options, choosing options and implementing a plan, evaluating the results, and reevaluating the plan.

36. Assign the client and family homework exercises to use and record use of newly learned problem-solving skills; process results in session.

19. Report more control over impulses and thoughts, and a slower thinking process. (37, 38, 39)

37. Verbally reinforce the client's slower speech and more deliberate thought process.

38. Reinforce increased control over hyperactivity and help the client set goals and limits on agitation; model and role-play increased behavioral control.

39. Monitor the client's energy level and reinforce increased control over behavior, pressured speech, and expression of ideas.

20. Participate in periodic "tune- up" sessions. (40)

40. Hold periodic "booster sessions" within the first few months after therapy to facilitate the client's positive changes; problem-solve obstacles to improvement.

21. Develop a personal recovery plan that includes all of the elements necessary to control mania/hypomania and to recover from addiction. (41, 42)

41. Outline with the client the essential components for managing manic/hypomanic states and addiction (e.g., taking medication, complying with medical monitoring, continuing therapy, attending recovery groups regularly, using a higher power, getting a sponsor, helping others in recovery).

42. Help the client to decide what environment he/she needs in early recovery to stabilize mood and maintain abstinence.

22. Write a 12-step program's Step Four inventory, and share with someone in recovery. (43)

23. Verbalize the importance of consistently attending recovery groups and of helping others in recovery. (44, 45)

24. Complete a re-administration of objective tests of mania/ hypomania as a means of assessing treatment outcome. (46)

25. Complete a survey to assess the degree of satisfaction with treatment. (47)

43. Using a 12-step recovery program's Step Four inventory, assign the client to write an autobiography and then to share it with someone in recovery.

44. Teach the client the importance of working a program of recovery that includes attending recovery group meetings regularly and helping others.

45. Arrange for the client to meet a 12-step program contact person, and assign him/her to talk about manic/hypomanic states and addictive behavior.

46. Assess the outcome of treatment by re-administering to the client objective tests of mania/ hypomania; evaluate the results and provide feedback to the client.

47. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	301.13	Cyclothymic Disorder
	295.70	Schizoaffective Disorder
	296.80	Bipolar Disorder NOS
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MEDICAL ISSUES

BEHAVIORAL DEFINITIONS

1. Has been diagnosed with medical problems that complicate recovery from addiction.
2. Presents with medical problems that require medical monitoring of medications or assistance with mobility.
3. Has organic brain syndrome that compromises learning, as a result of use of mood-altering chemicals.
4. Demonstrates inability to self-administer prescribed medications.
5. Suffers from chronic pain syndrome, which places the client at high risk for relapse.
6. Has medical problems that require medical/nursing assistance.
7. Self-medicates medical problems through use of mood-altering chemicals.
8. Reports negative emotions concerning medical illness that led to addiction.
9. Demonstrates a compromised ability to concentrate on recovery due to the severity of medical problems.
10. Blames substance abuse on medical issues and denies a primary substance abuse disorder.
11. Doctor shops in order to obtain the medication necessary to reduce symptoms.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and the negative effects of medical issues.
2. Resolve medical problems and return to a normal level of functioning.
3. Understand the relationship between medical issues and addiction.
4. Reduce the impact of medical problems on recovery and relapse potential.
5. Improve coping skills with organic brain syndrome, to allow for a self-directed program of recovery.
6. Understand and participate in the medical management of physical health problems.
7. Contact all prescribing medical personal and inform them of the patient's doctor shopping and addiction.

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SHORT-TERM OBJECTIVES

1. Verbalize an acceptance of the powerlessness and unmanageability that results from using addictive behavior to cope with medical problems. (1)

2. Identify medical problems and how these relate to addiction. (2)

3. Complete psychological testing or objective questionnaires for

THERAPEUTIC INTERVENTIONS

1. Help the client see the powerlessness and unmanageability that result from medical issues and addiction (or assign the Step One exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Explore the client's medical history and help him/her to see the relationship between his/her medical problems and addictive behavior (or assign "Coping with Addiction and Other Medical Problems" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

3. Administer to the client psychological instruments

assessing coping with medical problems. (3)	designed to objectively assess coping with medical problems (e.g., Beck Depression Inventory-FastScreen for Medical Patients [BDI-FastScreen]; Coping with Health, Injuries, and Problems [CHIP]); give the client feedback regarding the results of the assessment.
4. Verbalize an acceptance of the seriousness of medical problems and addictive behavior. (4)	4. Teach the client about medical issues and addiction, and how each of these illnesses poses a serious risk to his/her welfare.
5. List the negative consequences that resulted from using addiction to cope with medical problems. (2, 5, 6)	2. Explore the client's medical history and help him/her to see the relationship between his/her medical problems and addictive behavior (or assign "Coping with Addiction and Other Medical Problems" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz). 5. Help the client to develop a list of negative consequences that occurred because of using addictive behavior to cope with medical problems. 6. Educate the client regarding the negative impact of addictive behavior on bodily functioning and systems.
6. Visit with a physician for examination of the medical condition and addiction, and cooperate with treatment plan. (7, 8)	7. Physician to examine the client and to make recommendations as indicated to treat the medical condition and alleviate symptoms. 8. Monitor the client's compliance with the treatment plan as ordered by the physician; redirect the client as needed.
7. Verbalize an understanding of the medical condition, the treatment options, and prognosis. (9, 10, 11, 12)	9. Help the client to understand his/her medical problem and the need to cooperate with medical management.

10. Provide the client with references to literature of other informational resources regarding his/her medical condition.
11. Facilitate the medical personnel's teaching the client about his/her medical condition and discussing the treatment plan and prognosis.
12. Help the client to understand the importance of medical management and follow-up in aftercare.

8. Participate in decisions regarding the medical management of biomedical problems. (7, 13)

7. Physician to examine the client and to make recommendations as indicated to treat the medical condition and alleviate symptoms.
13. Teach the client assertiveness skills, and encourage the implementation of assertiveness in obtaining information about and becoming involved in the management of his/her medical treatment (or assign "How I Feel About My Medical Treatment" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

9. List 10 things to do to improve physical functioning. (14)

14. After a consultation with the medical staff, help the client to list 10 actions that he/she can take to improve physical functioning (e.g., take medications, maintain abstinence, practice relaxation, implement proper diet, rest and exercise, keep regular follow-up appointments with the physician).

10. Implement relaxation exercises as a pain management technique. (15)

15. Teach the client a variety of ways to manage chronic pain (or assign the "Learning to Self-Soothe" exercise from the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

11. Accept and follow through on a referral to a pain management clinic. (16)

16 Refer the client to a pain clinic for medical and psychological management of pain.

12. Discuss with family members the medical problems and addiction, and make plans for family members to obtain supportive services. (17)

13. List ways in which a higher power can assist in recovery from medical issues and addictive behavior. (18, 19)

14. Write a personal recovery plan that includes regular attendance at recovery groups and any medical treatment necessary to control medical issues and addiction. (20)

15. Family members verbalize what each can do to assist the client in recovery. (21, 22)

17. In a family session, discuss the medical issues and addiction, and make recommendations for family members to obtain supportive services (e.g., Al-Anon, Alateen, medical support group).

18. Teach the client the 12-step recovery program's concept of a higher power, and help him/her to see how a higher power can be helpful in recovery (e.g., pray for assistance with medical problems, practice regular meditation, attend religious activities to gain support).

19. Teach the client how prayer and meditation can be used in daily recovery (or assign the client to complete the Step Eleven exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

20. Help the client to develop a personal recovery plan that details what he/she is going to do in recovery to remain abstinent and to treat biomedical issues such as attend recovery groups regularly, make medical visits regularly, take medication as indicated, get a sponsor, attend aftercare, help others (or assign "Physical and Emotional Self-Care" or "Personal Recovery Planning" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

21. Discuss with family members the connection between the client's medical issues and his/her addictive behavior; review the steps that the client must take to recover successfully.

16. Complete a re-administration of objective tests of coping with medical problems as a means of assessing treatment outcome. (23)

17. Complete a survey to assess the degree of satisfaction with treatment. (24)

22. In a family session, review what each member can do to assist the client in recovery.

23. Assess the outcome of treatment by re-administering to the client objective tests of coping with medical problems; evaluate the results and provide feedback to the client.

24. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	307.89	Pain Disorder Associated with Psychological Factors and Axis III Disorder
	307.80	Pain Disorder Associated with Psychological Factors
	300.7	Hypochondriasis
	300.81	Somatization Disorder
	316	Personality Traits Affecting (Axis III Disorder)
	316	Maladaptive Health Behaviors Affecting (Axis III Disorder)
	316	Psychological Symptoms Affecting (Axis III Disorder)
	294.9	Cognitive Disorder NOS
	309.24	Adjustment Disorder with Anxiety
	309.0	Adjustment Disorder with Depressed Mood
	309.3	Adjustment Disorder with Disturbance of Conduct
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NARCISSISTIC TRAITS

BEHAVIORAL DEFINITIONS

1. Displays a grandiose sense of self-importance and self-worth.
2. Reports fantasies about unlimited power, success, intelligence, or beauty.
3. Verbalizes a belief in being a special person who is appreciated by other special people.
4. Demonstrates a powerful need to be recognized, admired, and adored.
5. Becomes angry and resentful when wishes, wants, and needs are not met immediately by others.
6. Demonstrates a lack of empathy for others.
7. Verbalizes unreasonable expectations of others in relationships, with little concern for the other person.
8. Verbalizes envy of others or feeling others are envious of them.
9. Brags about achievements, exaggerated abilities, and body image.
10. Is interpersonally manipulative and exploitive.
11. Is overly demanding in interpersonal relationships having little empathy for the needs, wishes, and wants of the significant other.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and the negative effects of narcissistic traits.
2. Develop a realistic sense of self, without narcissistic grandiosity, exaggeration, or sense of entitlement.
3. Understand the relationship between narcissistic traits and addiction.
4. Understand narcissistic traits and how the sense of omnipotence places the client at high risk for relapse.
5. Develop empathy for other people, particularly victims of his/her narcissism.
6. Learn and demonstrate healthy impulse-control skills.
7. Learn how cognitive distortions create unrealistic expectations from others.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Verbalize the powerlessness and unmanageability that results from narcissistic traits and addiction. (1)	1. Help the client see that narcissistic traits and addictive behavior lead to a state of powerlessness and unmanageability (or assign the client to complete the Step One exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
2. Verbalize an identification of several narcissistic traits and describe how they contribute to addictive behavior. (2, 3)	2. Assist the client in identifying his/her narcissistic traits, and how they can lead to addictive behavior. 3. Help the client to identify times when narcissistic traits and addictive behavior led to negative consequences.
3. Complete psychological testing or objective questionnaires for assessing narcissistic traits. (4)	4. Administer to the client psychological instruments designed to objectively assess

	narcissistic traits (e.g., Millon Clinical Multiaxial Inventory [MCMI]); give the client feedback regarding the results of the assessment.
4. Verbalize a commitment to honesty and humility that can form the basis for a program of recovery. (5, 6, 7)	5. Teach the client how a 12-step recovery program can assist in recovery from narcissistic traits and addiction. 6. Teach the client that honesty is essential for real intimacy, and explain how lies lead to interpersonal frustration and loneliness. 7. Discuss why resolution of narcissistic traits, especially the tendency toward dishonesty and feeling superior and all-powerful, is essential in maintaining abstinence.
5. List 10 lies that were told to exaggerate accomplishments and to seek acceptance and recognition. (8)	8. Assign the client to list common lies told to exaggerate accomplishments and bolster self-image; show why the self-defeating lies eventually led to the rejection from others that he/she feared.
6. List several narcissistic strategies used to manipulate others in relationships. (9)	9. Assist the client in listing ways in which he/she can use narcissistic traits to control and manipulate others; explain how narcissistic behaviors are counterproductive to interpersonal acceptance and respect.
7. Identify with the vulnerable revelations of other people by sharing similar experiences, feelings, and thoughts. (10, 11)	10. Conduct or refer the client for group therapy sessions that focus on developing empathy, by asking him/her to share with the group members his/her similar vulnerable, anxious experiences, feelings, and/or thoughts. 11. Use role-playing, modeling, and behavior rehearsal to teach the

client self-disclosure of feelings of vulnerability.

8. Verbalize how the dynamics of the family of origin led to a poor self-image and a sense of rejection and failure. (12)

12. Probe the client's family of origin for experiences of criticism, emotional abandonment or rejection, and abuse or neglect that led to feelings of low self-esteem masked by narcissism.

9. Identify a pattern of inaccurate thoughts (e.g., anxious, fearful thoughts followed the exaggerated thoughts of power and importance) and replace these thoughts with accurate, but realistic, self-talk. (13, 14)

13. Probe the client's narcissistic thoughts (e.g., grandiosity, sense of entitlement, tendency to blame others, need to exaggerate achievements in search of acceptance); show the client how these thoughts are based in low self-esteem and an expectation of rejection, then replace this pattern with confident, realistic self-talk.

14. Teach the client to replace cognitive messages of low self-esteem and fear of rejection with more realistic, healthy, and adaptive self-talk.

10. Acknowledge that low self-esteem and fear of failure or rejection are felt internally, in spite of the external facade of braggadocio. (15, 16)

15. Confront expressions of entitlement and braggadocio, interpreting them as a cover for feelings of fear and low self-esteem.

16. Reinforce the client's social interactions that are characterized by humility, empathy, honesty, and compassion (or assign "Getting Out of Myself" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

11. List ways in which a higher power can assist in recovery from narcissistic traits and addiction. (17, 18)

17. Teach the client about the 12-step recovery program's concept of a higher power and how this can be used in recovery (e.g., see God, not self, as the higher power, trust God to help with temptations, help others in recovery, and practice regular prayer and meditation).

18. Teach the client how to turn over problems to a higher power (or assign the client to complete the Step Three exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

12. Verbalize a commitment to helping others as essential to recovery from narcissistic traits and addictive behavior. (16, 19)

16. Reinforce the client's social interactions that are characterized by humility, empathy, honesty, and compassion (or assign "Getting Out of Myself" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

19. Teach the client that helping others will give him/her a genuine sense of self-worth, which is essential to working a good program of recovery (or assign "Being Genuinely Unselfish" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

13. Practice honesty and realistic humility in communication with others. (16, 20, 21)

16. Reinforce the client's social interactions that are characterized by humility, empathy, honesty, and compassion (or assign "Getting Out of Myself" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

20. Using modeling, role-playing, and behavior rehearsal, teach the client the impulse control skills of stopping, looking, listening, thinking, and planning before acting without regard for others' feelings.

21. Using modeling, role-playing, and behavior rehearsal, teach the client healthy interpersonal communication skills (e.g., honesty, ask for what you want, share how you feel, care about what the other person wants, active

	listening, and the use of "I messages").
14. Write a personal recovery plan that details the regular attendance at recovery groups and further treatments that are needed to recover from narcissistic traits and addictive behavior. (22)	22. Help the client to develop a personal recovery plan that will detail what he/she is going to do for further treatment in recovery such as attend recovery groups regularly, get a sponsor, or seek further treatment or therapy (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
15. Family members verbalize what each can do to assist the client in recovery. (23, 24, 25)	23. Discuss with family members the connection between narcissistic traits and addictive behavior. 24. In a family session, review what each member can do to assist the client in recovery. 25. Provide family members with information about narcissistic traits and the steps that the client must take to recover successfully.
16. Complete a re-administration of objective tests of narcissistic traits as a means of assessing treatment outcome. (26)	26. Assess the outcome of treatment by re-administering to the client objective tests of narcissistic traits; evaluate the results and provide feedback to the client.
17. Complete a survey to assess the degree of satisfaction with treatment. (27)	27. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	301.13	Cyclothymic Disorder
	_____	_____
	_____	_____
Axis II:	301.81	Narcissistic Personality Disorder
	301.83	Borderline Personality Disorder
	301.50	Histrionic Personality Disorder
	_____	_____
	_____	_____

NICOTINE ABUSE/DEPENDENCE

BEHAVIORAL DEFINITIONS

1. Demonstrates a maladaptive pattern of tobacco use, manifested by increased tolerance and withdrawal.
2. Is unable to stop or cut down use of tobacco once started, despite the verbalized desire to do so and the negative consequences continued use brings.
3. Exhibits physical indicators (chronic obstructive lung disease, bronchitis, lung cancer, oral cancers, etc.) that reflect the results of a pattern of heavy tobacco use.
4. Denies that nicotine dependence is a problem, despite feedback from significant others that the use of tobacco is negatively affecting them and others.
5. Continues tobacco use despite knowledge of experiencing persistent physical, financial, vocational, social, and/or relationship problems that are directly caused by the use of nicotine.
6. Presents with physical withdrawal symptoms (e.g., nicotine craving, anxiety, insomnia, irritability, depression) when going without nicotine for any length of time.
7. Consumes tobacco in greater amounts than intended.
8. Continues to use mood-altering chemicals after being told by a physician that using is causing health problems.
9. Nicotine dependence is concurrent with other addictive behaviors, and their practice reinforces one another.

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LONG-TERM GOALS

1. Accept the powerlessness and unmanageability over tobacco, and participate in a recovery-based program of abstinence.
2. Accept chemical dependence on tobacco and begin to actively participate in a recovery program.
3. Withdraw from tobacco, stabilize physically and emotionally, and then establish a supportive recovery plan.
4. Establish and maintain total abstinence from tobacco products while increasing knowledge of the addiction and the process of recovery.
5. Acquire the necessary skills to maintain long-term sobriety from all mood-altering substances.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Cooperate with a medical assessment and an evaluation of the necessity for pharmacological intervention, taking medications as directed. (1, 2)	1. Refer the client to a physician to perform a physical exam and write treatment orders, including, if necessary, prescribing medications, monitoring the effectiveness and side effects of medication, and titrating as necessary. 2. Direct the staff to administer prescribed medications to the client and monitor for effectiveness and side effects.
2. Complete psychological testing or objective questionnaires for assessing nicotine abuse/dependence. (3)	3. Administer to the client psychological instruments designed to objectively assess nicotine abuse/dependence (e.g., Addiction Severity Index [ASI], Substance Abuse Subtle Screening Inventory 3 [SASSI-3], Fagerstrom Test for

	Nicotine Dependence [FTND]); give the client feedback regarding the results of the assessment.
3. Report acute withdrawal symptoms to the staff. (4)	4. Direct the staff to assess and monitor the client's condition during withdrawal.
4. Provide honest and complete information for a chemical dependence biopsychosocial history. (5)	5. Complete a thorough family and personal biopsychosocial history that has a focus on nicotine abuse and any other addictions.
5. Attend didactic sessions and read assigned material in order to increase knowledge of tobacco abuse and the process of recovery. (6, 7, 8)	6. Assign the client to attend a nicotine dependence didactic series to increase knowledge of the patterns and effects of nicotine dependence.
	7. Require the client to attend all nicotine dependence didactics; ask him/her to identify several key points attained from each didactic, and process these points with the therapist.
	8. Ask the client to read literature of nicotine dependence etiology and its negative social, emotional, and medical consequences; process with the therapist five key points gained from the reading.
6. Attend group therapy sessions to share thoughts and feelings associated with reasons for, consequences of, feelings about, and alternatives to nicotine abuse. (9, 10)	9. Assign the client to attend group therapy that focuses on nicotine dependence recovery issues.
	10. Direct group therapy that facilitates the sharing of causes for, consequences of, feelings about, and alternatives to nicotine dependence.
7. List the negative consequences resulting from or exacerbated by nicotine dependence. (11)	11. Ask the client to make a list of the ways in which nicotine dependence has negatively impacted his/her life; process the list with the therapist or group.
8. Verbally admit to powerlessness over nicotine. (12)	12. Assign the client to complete a 12-step program's Step One paper

	admitting to powerlessness over nicotine, and present it in group therapy or to the therapist for feedback.
9. Verbalize a recognition that nicotine was used as the primary coping mechanism to escape from stress or pain, and resulted in negative consequences. (13)	13. Explore how nicotine abuse was used to escape from stress, physical and emotional pain, and boredom; confront the negative consequences of this pattern.
10. List the negative emotions that were caused by or exacerbated by nicotine dependence. (14)	14. Probe the sense of powerlessness, shame, guilt, and low self-worth that has resulted from nicotine abuse and its consequences.
11. Develop a list of social, emotional, and family factors that contributed to nicotine dependence. (5, 15)	5. Complete a thorough family and personal biopsychosocial history that has a focus on nicotine abuse and any other addictions. 15. Using the biopsychosocial history, assist the client in understanding the familial, emotional, and social factors that contributed to the development of nicotine dependence (e.g., modeling effects of older adults, peer pressure and anxiety).
12. List 10 reasons to work on a plan for recovery from nicotine use. (12, 14, 16)	12. Assign the client to complete a 12-step program's Step One paper admitting to powerlessness over nicotine, and present it in group therapy or to the therapist for feedback. 14. Probe the sense of powerlessness, shame, guilt, and low self-worth that has resulted from nicotine abuse and its consequences. 16. Assign the client to write a list of 10 reasons to be abstinent from nicotine dependence.
13. List 10 lies used to hide nicotine abuse. (17)	17. Help the client see the dishonesty that accompanies nicotine dependence; have him/her list 10 lies they told to hide tobacco use,

and then teach him/her why honesty is essential to recovery.

14. Report success in practicing turning problems over to a higher power each day. (18, 19)

18. Teach the client about the concept of a higher power and how this can assist in recovery (e.g., God's power can assist in resisting temptation, regular prayer and meditation can reduce craving and stress).

19. Using a recovery program's Step Three exercise, teach the client about the concept of "turning it over," then assign turning over problems to a higher power each day; have the client record the event and discuss the results.

15. Practice health communication skills to reduce interpersonal stress and increase positive social interaction. (20, 21)

20. Teach the client healthy communication skills (e.g., using "I messages," reflecting, active listening, empathy, being reinforcing, sharing).

21. Refer the client for or teach him/her social interaction skills to reduce the interpersonal anxiety that triggered nicotine use.

16. Practice problem-solving skills. (22)

22. Using modeling, role-playing, and behavior rehearsal, teach the client how to solve problems in an organized fashion (i.e., write the problem, think accurately, list the options of action, evaluate alternatives, act, monitor, and evaluate results); select a problem the client is facing and apply the problem solving process to this problem (or assign "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

17. List the reasons for nicotine use and the ways the same things can be attained in an adaptive manner. (23, 24)

23. Using progressive relaxation or biofeedback, teach the client how to relax; assign him/her to relax twice a day for 10 to 20 minutes.

24. Assist the client in clarifying why he/she was using nicotine, and help him/her to identify adaptive ways to obtain the sought-after result such as relaxation (or assign "Learning to Self-Soothe" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

18. Practice stress management and relaxation skills to reduce overall stress levels and attain a feeling of relaxation and comfort. (23, 25)

23. Using progressive relaxation or biofeedback, teach the client how to relax; assign him/her to relax twice a day for 10 to 20 minutes.

25. Using current physical fitness levels, urge the client to exercise three times a week; increase the exercise by 10 percent a week, until he/she is exercising at a training heart rate for at least 20 minutes at least three times a week.

19. Make a written plan to cope with each high-risk trigger situation that may precipitate relapse. (13, 26, 27, 28)

13. Explore how nicotine abuse was used to escape from stress, physical and emotional pain, and boredom; confront the negative consequences of this pattern.

26. Using a relapse prevention exercise, help the client uncover his/her triggers for relapse into nicotine dependence.

27. Teach the client about high-risk situations (e.g., negative emotions, social pressure, interpersonal conflict, positive emotions, testing personal control); assist the client in making a written plan to cope with each high-risk situation (or assign "Avoiding Nicotine Relapse Triggers" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

28. Using modeling, role-playing, and behavior rehearsal, teach the client

	how to say no to nicotine, alcohol, or drugs; practice saying no in high-risk situations.
20. Identify rewards for nicotine abstinence. (29)	29. Assist the client in identifying reinforcing events that could be used in rewarding abstinence from nicotine.
21. Implement a structured behavior modification program for nicotine abstinence. (30, 31, 32)	30. Design, with the client, a behavior modification program that targets nicotine abuse and reinforces periods of abstinence.
	31. Assign implementation of a behavior modification program that stipulates rewards for nicotine abstinence.
	32. Review, process, and redirect the behavior modification to maximize success rates.
22. Comply with a referral to a physician for an evaluation of nicotine replacement therapy or prescription medication. (33, 34)	33. Refer to a physician for an evaluation of the safety and potential efficacy of nicotine replacement therapy (e.g., patch or gum) to be used in conjunction with a smoking cessation program.
	34. Refer to a physician for an evaluation of the safety and potential efficacy of a medication (e.g., Wellbutrin, Zyban, Chantix) for smoking cessation and relapse prevention in conjunction with a smoking cessation program.
23. Report any side effects and on the effectiveness of the nicotine replacement therapy or prescription medication to appropriate professionals. (35, 36)	35. Educate the client about the use, side effects, and expected benefits of psychotropic medications.
	36. Monitor the client's medication compliance, side effects, and effectiveness.
24. Discontinue nicotine replacement therapy and/or prescription medication under physician supervision. (37)	37. Work with a physician to help the client discontinue nicotine replacement therapy and/or prescription medication after a

sufficient period of abstinence from tobacco use.

25. Complete a re-administration of objective tests of nicotine abuse/dependence as a means of assessing treatment outcomes. (38)

26. Complete a survey to assess the degree of satisfaction with treatment. (39)

38. Assess the outcome of treatment by re-administering to the client objective tests of nicotine abuse/dependence; evaluate the results and provide feedback to the client.

39. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	305.10	Nicotine Dependence
	292.0	Nicotine Withdrawal
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	_____	_____

OCCUPATIONAL PROBLEMS

BEHAVIORAL DEFINITIONS

1. Reports feelings of inadequacy, fear, and failure following severe business losses.
2. Has a history of rebellion against and/or conflicts with authority figures in the employment situation.
3. Is unemployed due to the negative effects of addictive behavior on work performance and attendance.
4. Reports that work environment is too stressful, leading to addictive behavior to escape stress.
5. Works with people who are alcohol and/or drug abusers and are supportive of addiction, increasing the risk for relapse.
6. Risks loss of job due to addictive behavior.
7. Lacks employer understanding of addiction or what is required for recovery.
8. Retirement has led to feelings of loneliness, lack of meaning in life, and addictive behavior.
9. Experiences anxiety related to perceived or actual job jeopardy due to addictive behavior.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and occupational problems.
2. Educate employers and coworkers to be supportive of recovery.
3. Fill life with new interests, so retirement can be appreciated.
4. Understand the relationship between the stress of occupational problems and addiction.
5. Make a contract with management that details the recovery plan and consequences of relapse.
6. Cooperate with a program that will lead to becoming employed again.

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SHORT-TERM OBJECTIVES

1. Identify occupational problems and how they relate to addiction. (1, 2)

2. Complete psychological testing or objective questionnaires for assessing occupational problems. (3)

3. Identify own role in the conflict with coworkers or supervisor. (4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Take a history of the client's occupational problems; explore what employment patterns were modeled in the family of origin.
2. Teach the client how his/her occupational problems led to his/her addiction.
3. Administer to the client psychological instruments designed to objectively assess occupational problems (e.g., 16 PF); give the client feedback regarding the results of the assessment.
4. Confront projection of responsibility for the client's behavior and feelings onto others.
5. Assist the client in identifying his/her patterns of interpersonal conflicts that occur beyond the

	work setting; relate these patterns to current occupational problems.
	6. Probe family-of-origin history for how the client may have learned dysfunctional relationship patterns; relate these patterns to current coworker/supervisor conflicts (or assign the "Understanding Family History" exercise in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
4. Identify own behavioral changes that would help resolve conflict with coworkers or supervisors. (7, 8)	7. Assist the client in listing behavioral changes that he/she could make to resolve conflicts with coworkers and supervisors; assign implementation of these changes.
	8. Review the client's attempts to implement behavioral changes at work; reinforce success and redirect for failure.
5. Acknowledge the interaction between occupational problems and addictive behavior. (9, 10)	9. Help the client to list times when addictive behavior led to problems at work.
	10. Assign the client to list times that occupational problems led to addictive behavior (or assign "Barriers and Solutions" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
6. Verbalize why current employment increases the risk for relapse. (10, 11)	10. Assign the client to list times that occupational problems led to addictive behavior (or assign "Barriers and Solutions" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
	11. Help the client to see why his/her current employment is a high risk for relapse (e.g., coworker's addictions, job dissatisfaction, supervisor conflict, work hours too

	long, absence from his/her family due to travel, ethical conflicts).
7. Verbalize feelings of fear, anger, and helplessness associated with the vocational stress. (12)	12. Probe and clarify the client's emotions regarding his/her vocational situation.
8. Identify distorted cognitive messages associated with perception of job stress. (13, 14)	13. Assess and make the client aware of his/her distorted, negative cognitive messages and the schema that is connected with vocational stress (or assign "A Vocational Action Plan" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
	14. Confront the client's catastrophizing the situation, leading to immobilizing anxiety.
9. Develop healthier, more realistic cognitive messages that promote harmony with others, self-acceptance, and self-confidence. (15)	15. Teach the client more realistic, healthy cognitive messages that relieve anxiety and depression (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
10. Develop a written plan to resolve occupational problems and maximize chances for recovery in the workplace. (16, 17, 18)	16. Help the client develop a written plan to resolve occupational problems and maximize recovery (e.g., regular attendance at recovery groups, regular drug testing, management monitors recovery plan, honesty with management and coworkers).
	17. Meet with the client and his/her employer to educate the employer about addiction and to gain support for treatment and recovery.
	18. Help the client to learn the skills necessary to remain abstinent in his/her current work environment (e.g., honesty with management and coworkers, regular attendance at recovery group meetings, using a sponsor, eliciting the support of management, continued treatment).

11. Implement the assertiveness skills that are necessary to be honest with coworkers about addiction and recovery. (19, 20)

12. List the skills or changes that will help in coping with the stress of the current occupation. (21)

13. List five ways in which working a program of recovery will improve occupational problems. (18, 22)

14. Make written plans to change employment to a job that will be supportive to recovery. (23)

15. Turn the stress of occupational problems and the urge for addictive behavior over to a higher power at least once a day. (24, 25)

18. Help the client to learn the skills necessary to remain abstinent in his/her current work environment (e.g., honesty with management and coworkers, regular attendance at recovery group meetings, using a sponsor, eliciting the support of management, continued treatment).

19. Using modeling, role-playing, and behavior rehearsal, have the client practice telling his/her coworkers and employer the truth about his/her addictive behavior and plans for recovery.

20. Use role-playing, behavior rehearsal, and modeling to teach the client assertiveness skills.

21. Help the client to develop skills to reduce job stress and improve employment satisfaction (e.g., time management; relaxation; exercise; assertiveness; reducing responsibilities, work hours, and/or travel time, realistic expectations of work performance).

22. Teach the client how working a 12-step recovery program will improve occupational problems.

23. Help the client to accept the need to change jobs, to employment that will be more supportive to recovery (or assign "Interest and Skill Self-Assessment" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

24. Teach the client about the 12-step recovery program's concept of a higher power and how this can assist in recovery.

	25. Teach the client how to turn problems over to a higher power; assign him/her to practice turning problems over to a higher power at least once a day (or assign the client to complete the Step Three exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
16. Honestly acknowledge the negative impact that addiction has had on work performance. (9, 26)	9. Help the client to list times when addictive behavior led to problems at work.
	26. Help the client to be honest with himself/herself, coworkers, and management about the negative impact of addictive behavior on job performance; list the negative consequences of addictive behavior on employment.
17. Enter a Supported Employment Program. (27)	27. Refer the client to an evidence-based Supported Employment Program; consult as needed with its staff and follow the client's progress.
18. Discuss the grief over retirement, and make written plans to replace addictive behavior with specific constructive activities. (28, 29)	28. Explore and resolve the client's feelings associated with retirement.
	29. Assist the client in making plans to engage in constructive activities (e.g., volunteering, hobbies, exercise, social contacts, special-interest groups, 12-step recovery program meetings, continuing education, religious involvement).
19. Family members verbalize what each can do to assist the client in recovery. (30, 31)	30. Discuss with family members the connection between occupational problems and addictive behavior.
	31. In a family session, review what each member can do to assist the client in recovery.
20. Complete a re-administration of objective tests of occupational	32. Assess the outcome of treatment by re-administering to the client

problems as a means of assessing treatment outcome. (32)

21. Complete a survey to assess the degree of satisfaction with treatment. (33)

objective tests of occupational problems; evaluate the results and provide feedback to the client.

33. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	V62.81	Relational Problem NOS
	V62.2	Occupational Problem
	V62.89	Phase of Life Problem
	300.02	Generalized Anxiety Disorder
	311	Depressive Disorder NOS
	309.0	Adjustment Disorder with Depressed Mood
	309.24	Adjustment Disorder with Anxiety
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.0	Paranoid Personality Disorder
	_____	_____
	_____	_____

OPIOID DEPENDENCE

BEHAVIORAL DEFINITIONS

1. Demonstrates a pattern of opioid use leading to clinically significant impairment or distress.
2. Reports a need for markedly increased amounts of opioids to achieve the desired effect.
3. Presents with withdrawal symptoms characteristic of opioid dependence.
4. Verbalizes a persistent desire to cut down or control opioid use.
5. Spends a great deal of time trying to obtain opioids and recover from use.
6. Gives up important social, occupational, or recreational activities because of opioid use.
7. Engages in illegal activity to financially support the opioid habit.
8. Opioid abuse continues despite significant negative financial, legal, social, vocational, medical, familial, and self-esteem consequences.
9. Abuses opioids in a maladaptive response to pain management.

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LONG-TERM GOALS

1. Accept the powerlessness and unmanageability over opioids, and participate in a recovery-based program.
2. Withdraw from mood-altering substance, stabilize physically and emotionally, and then establish a supportive recovery plan.
3. Establish a sustained recovery, free from the use of all mood-altering substances.
4. Establish and maintain total abstinence while increasing knowledge of the disease and the process of recovery.
5. Acquire the necessary skills to maintain long-term abstinence from all mood-altering substances and live a life free of chemicals.

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SHORT-TERM OBJECTIVES

1. Cooperate with medical assessment and an evaluation of the necessity for pharmacological intervention. (1, 2)

2. Take prescribed medications as directed by the physician. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Refer the client to a physician to perform a physical examination (include tests for HIV, hepatitis, and sexually transmitted diseases) and discuss the use of methadone, buprenorphine, and the abstinence-based model of opioid treatment.
2. Refer the client to a pharmacology-based maintenance/withdrawal program (e.g., methadone, buprenorphine).
3. Physician will monitor the effectiveness and side effects of medication, titrating as necessary.
4. Staff will administer prescribed medications and monitor for effectiveness and side effects.

3. Report acute withdrawal symptoms to the staff. (5)

4. Complete psychological testing or objective questionnaires for assessing opioid dependence. (6)

5. Provide honest and complete information for a chemical dependence biopsychosocial history. (7)

6. Attend didactic sessions and read assigned material in order to increase knowledge of addiction and the process of recovery. (8, 9, 10, 11)

5. Assess and monitor the client's condition during withdrawal, using a standardized procedure (e.g., Narcotic Withdrawal Scale) as needed.

6. Administer to the client psychological instruments designed to objectively assess opioid dependence (e.g., Substance Use Disorders Diagnostic Schedule-IV [SUDDS-IV], Substance Abuse Subtle Screen Inventory-3 [SASS-3]); give the client feedback regarding the results of the assessment.

7. Complete a thorough family and personal biopsychosocial history that has a focus on addiction (e.g., family history of addiction and treatment, other substances used, progression of substance abuse, consequences of abuse).

8. Assign the client to attend a chemical dependence didactic series to increase his/her knowledge of the patterns and effects of chemical dependence.

9. Require the client to attend all chemical dependence didactics; ask him/her to identify several key points attained from each didactic and process these points with the therapist.

10. Assign the client to read material on addiction (e.g., *Willpower's Not Enough* by Washton, *The Addiction Workbook* by Fanning, or *Alcoholics Anonymous*); and process key points gained from the reading.

11. Require the client to read the book *Narcotics Anonymous* and gather five key points from it to process with the therapist.

7. Attend group therapy sessions to share thoughts and feelings associated with, reasons for, consequences of, feelings about, and alternatives to addiction. (12, 13)

8. Verbally admit to powerlessness over mood-altering substances. (14)

9. List and discuss negative consequences resulting from or exacerbated by substance dependence. (15, 16, 17)

10. Verbalize recognition that mood-altering chemicals were used as the primary coping mechanism to escape from stress or pain, and resulted in negative consequences. (18)

11. List and discuss the negative emotions that were caused by or exacerbated by substance dependence. (19)

12. Assign the client to attend group therapy.

13. Direct group therapy that facilitates the client sharing causes for, consequences of, feelings about, and alternatives to addiction.

14. Assign the client to complete a Narcotics Anonymous (NA) Step One paper admitting to powerlessness over mood-altering chemicals, and present it in group therapy or to therapist for feedback.

15 Ask the client to make a list of the ways chemical use has negatively impacted his/her life (or assign "Substance Abuse Negative Impact Versus Sobriety's Positive Impact" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); process the list in individual or group sessions.

16. Confront the client's use of denial to minimize the severity of and negative consequences of opioid abuse.

17. Using the biopsychosocial history and the client's list of negative consequences of opioid abuse, assist him/her in understanding the need to stay in treatment.

18. Explore how addiction was used to escape from stress, physical and emotional pain, and boredom; confront the negative consequences of this pattern.

19. Probe the client's sense of shame, guilt, and low self-worth that has resulted from addiction and its consequences.

12. List and discuss reasons to work on a plan for recovery from addiction. (20)

20. Assign the client to write a list of reasons to be abstinent from addiction (or assign "Making Change Happen" or "A Working Recovery Plan" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

13. List lies used to hide substance dependence. (21, 22)

21. Help the client see the dishonesty that goes along with addiction; ask him/her to list lies told to hide substance use.

22. Teach the client why honesty is essential to recovery.

14. Verbalize ways a higher power can assist in recovery. (23)

23. Teach the client about the AA concept of a higher power and how this can assist in recovery (e.g., God can help with chronic pain or craving, regular prayer and meditation can reduce stress).

15. Identify and accept the need for substance abuse treatment. (24)

24. Conduct Motivational Interviewing to assess the client's stage of preparation for change; intervene accordingly, moving from building motivation, through strengthening commitment to change, to participation in treatment (see *Motivational Interviewing,* 2nd ed. by Miller and Rollnick).

16. Identify realistic goals for substance abuse recovery. (25, 26, 27)

25. Assign the client to meet with an AA/NA member who has been working the 12-Step program for several years and find out specifically how the program has helped him/her to stay sober; afterward, process the meeting.

26. Request that the client write out basic treatment expectations (e.g., physical changes, social changes, emotional needs) regarding sobriety, and process these with the clinician.

27. Emphasize the goal of substance abuse recovery and the need for sobriety, despite lapses or relapses.

17. Verbalize a commitment to abstain from the use of mood-altering drugs. (28)

28. Develop an abstinence contract with the client regarding the termination of the use of his/her drug; process the client's feelings related to the commitment.

18. Identify and make changes in social relationships that will support recovery. (29)

29. Review the negative influence of the client continuing his/her alcohol-related friendships ("drug buddies") and assist him/her in making a plan to develop new sober relationships including "sobriety buddies"; revisit routinely and facilitate toward development of a new social support system.

19. Identify projects and other social and recreational activities that sobriety will now afford and that will support sobriety. (30, 31)

30. Assist the client in planning social and recreational activities that are free from association with substance abuse; revisit routinely and facilitate toward development of a new set of activities.

31. Plan household, work-related, and/or other free-time projects that can be accomplished to build the client's self-esteem and self-concept as clean and sober.

20. Verbalize how the living situation contributes to chemical dependence and acts as a hindrance to recovery. (32)

32. Evaluate the role of the client's living situation in fostering a pattern of chemical dependence; process with the client toward identifying therapeutic changes.

21. Make arrangements to terminate current living situation and move to a place more conducive to recovery. (33)

33. Facilitate development of a plan for the client to change his/her living situation to foster recovery; revisit routinely and facilitate toward accomplishing a positive change in living situation.

22. Identify the positive impact that sobriety will have on intimate and

34. Assist the client in identifying positive changes that will be made

family relationships. (34)

23. Agree to make amends to significant others who have been hurt by the life dominated by substance abuse. (35, 36)

24. Participate in behavioral marital or family therapy to learn and implement ways to improve relations, resolve conflicts, solve problems, and communicate effectively. (37)

25. Learn and implement personal coping strategies to manage urges to lapse back into chemical use. (38)

26. Identify, challenge, and replace destructive self-talk with positive, strength building self-talk. (39, 40)

in family relationships during recovery.

35. Discuss the negative effects the client's substance abuse has had on family, friends, and work relationships and encourage a plan to make amends for such hurt.

36. Elicit from the client a verbal commitment to make initial amends now to key individuals now and further amends later.

37. Refer or provide behavioral couples or family therapy (see the chapters on Partner Relational Conflict or Parenting in this *Planner*).

38. Teach the client tailored coping strategies involving calming strategies (e.g., relaxation, breathing), thought-stopping, positive self-talk, and attentional focusing skills (e.g., distraction from urges, staying focused on behavioral goals of abstinence) to manage triggered urges to use chemical substances.

39. Use Cognitive Therapy approaches to explore the client's schema and self-talk that weaken his/her resolve to remain abstinent; challenge the biases; assist him/her in generating realistic self-talk that correct for the biases and build resilience.

40. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); review and reinforce success.

27. Participate in gradual repeated exposure to triggers of urges to lapse back into chemical substance use within individual or group therapy sessions and between them; review with group members and therapist. (41, 42)

41. Direct and assist the client in construction of a hierarchy of urge-producing cues to use substances (or assign "Identifying Relapse Triggers and Cues" or "Relapse Prevention Planning" in the *Addiction Treatment Homework Planner,* 4th ed. by Finley and Lenz).

42. Select initial *in vivo* or role-played cue exposures that have a high likelihood of being a successful experience for the client; facilitate coping and cognitive restructuring within and after the exposure, use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate the exposure, review with the client and group members, if done in group.

28. Learn and implement personal skills to manage common day-to-day challenges and build confidence in managing them without the use of substances. (43, 44)

43. Assess current skill in managing common everyday stressors (e.g., work, social, family role demands); use behavioral techniques (e.g., instruction, modeling, role-playing) to build social and/or communication skills to manage these challenges without the use of substances.

44. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).

29. Learn and implement pain management techniques as an alternative to coping through opioid use. (45)

45. Teach or refer client to a pain management program to learn alternatives to substance use for managing pain (see the chapter on Chronic Pain in this *Planner*).

30. Implement relapse prevention strategies for managing possible future situations with high-risk for relapse. (46, 47, 48, 49)

46. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse.

47. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

48. Request that the client identify feelings, behaviors, and situations that place him/her at a higher risk for substance abuse (or assign "Relapse Triggers" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

49. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships (or assign "Aftercare Plan Components" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

31. Structure time and increase self-esteem by obtaining employment. (50)

50. Refer the client to a supported employment program, or coach the client on preparing for employment, searching for a job, and maintaining employment (see the chapter on Occupational Problems in this *Planner*).

32. Verbalize that there are options to substance use in dealing with stress and in finding pleasure or excitement in life. (51, 52, 53)

51. Teach the client the importance of getting pleasure out of life without using mood-altering substances.

52. Assign the client in developing a list of pleasurable activities (see *Inventory of Rewarding Activities* by Birchler and Weiss); assign engagement in selected activities daily.

53. Encourage the client to establish a daily routine of physical exercise to build body stamina, self-esteem, and reduce depression (see *Exercising Your Way to Better Mental Health* by Leith).

33. Verbalize the results of turning problems over to God each day. (54)

54. Using a Step Three exercise, teach the client about the recovery concept of "turning it over"; then assign turning over problems to a higher power each day; ask the client to record the event and discuss the results.

34. Complete a re-administration of objective tests of opioid abuse as a means of assessing treatment outcome. (55)

55. Assess the outcome of treatment by re-administering to the client objective tests of opioid dependence; evaluate the results and provide feedback to the client.

35. Complete a survey to assess the degree of satisfaction with treatment. (56)

56. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	304.00	Opioid Dependence
	305.50	Opioid Abuse
	304.80	Polysubstance Dependence
	292.89	Opioid Intoxication
	292.0	Opioid Withdrawal
	292.9	Opioid-Related Disorder NOS
	_____	_____
	_____	_____

OPPOSITIONAL DEFIANT BEHAVIOR

BEHAVIORAL DEFINITIONS

1. Has a history of explosive, aggressive outbursts.
2. Often argues with authority figures over requests or rules.
3. Deliberately annoys people as a means of gaining control.
4. Blames others rather than accept responsibility for own problems.
5. Displays angry overreaction to perceived disapproval, rejection, or criticism.
6. Passively withholds feelings and then explodes in a violent rage.
7. Abuses substances to cope with feelings of anger and alienation.
8. Has a persistent pattern of challenging or disrespecting authority figures.
9. Demonstrates body language of tense muscles (e.g., clenched fists or jaw, glaring looks, or refusal to make eye contact).
10. Verbalizes a view of aggression as a means to achieve needed power and control.
11. Uses verbally abusive language.
12. Expresses deep resentment toward authority figures.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and oppositional defiant behavior.
2. Decrease the frequency of occurrence of angry thoughts, feelings, and behaviors.
3. Follow rules established by authority figures, without opposition or complaint.
4. Stop blaming others for problems and begin to accept responsibility for own feelings, thoughts, and behaviors.
5. Learn and implement stress management skills, to reduce the level of stress and the irritability that accompanies it.
6. Reach a level of reduced tension, increased satisfaction, and improved communication with family and/or other authority figures.
7. Parents learn and implement good child behavioral management skills.

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SHORT-TERM OBJECTIVES

1. Acknowledge feelings of anger and identify trigger situations. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Explore the client's angry feelings and assist him/her in identifying sources for his/her anger.
2. Assign the client to keep a daily anger log, writing down each situation that produced angry feelings and the thoughts associated with the situation; then rate the level of anger on a scale from 1 to 100; process the anger log, and assist in uncovering the dysfunctional thoughts that trigger anger.
3. Thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts,

	feelings, and actions that have characterized his/her anger responses.
2. Complete psychological testing or objective questionnaires for assessing defiance of authority. (4)	4. Administer to the client psychological instruments designed to objectively assess traits of oppositional defiance (e.g., Adolescent Psychopathology Scale-Short Form [APS-SF], Millon Adolescent Clinical Inventory [MACI]); give the client feedback regarding the results of the assessment.
3. Verbalize an understanding of how angry thoughts and feelings can lead to an increased risk of addiction. (5, 6, 7)	5. Educate the client about his/her tendency to use addictive behavior as a means of relieving uncomfortable feelings; develop a list of several instances of this occurrence.
	6. Teach the client about the high-risk situations of strong negative emotions, social pressure, interpersonal conflict, strong positive emotions, and testing personal control; discuss how anger, as a strong negative emotion, places him/her at high risk for addictive behavior.
	7. Assist the client in identifying reasons why anger increases the risk of relapse.
4. Cooperate with a physician evaluation for possible treatment with psychotropic medications to assist in anger and behavioral control and take medications consistently, if prescribed. (8)	8. Assess the client for the need for psychotropic medication to assist in control of anger; refer him/her to a physician for an evaluation for prescription medication; monitor prescription compliance, effectiveness, and side effects; provide feedback to the prescribing physician.
5. Agree to learn alternative ways to think about and manage anger and misbehavior. (9, 10)	9. Assist the client in reconceptualizing anger as involving different components (cognitive, physiological,

affective, and behavioral) that go through predictable phases (e.g., demanding expectations not being met leading to increased arousal and anger leading to acting out) that can be managed.

10. Assist the client in identifying the positive consequences of managing anger and misbehavior (e.g., respect from others and self, cooperation from others, improved physical health, etc.); ask the client to agree to learn new ways to conceptualize and manage anger and misbehavior.

6. Learn and implement calming strategies as part of a new way to manage reactions to frustration and defiance. (11)

11. Teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a tailored strategy for responding appropriately to angry feelings and the urge to defy when they occur.

7. Identify, challenge, and replace self-talk that leads to anger and misbehavior with self-talk that facilitates more constructive reactions. (12)

12. Explore the client's self-talk that mediates his/her angry feelings and actions (e.g., demanding expectations reflected in should, must, or have to statements); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration.

8. Learn and implement thought-stopping to manage intrusive unwanted thoughts that trigger anger and acting out. (13)

13. Assign the client to implement a "thought-stopping" technique on a daily basis between sessions (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); review implementation; reinforce success, providing

corrective feedback toward improvement.

9. Verbalize feelings of frustration, disagreement, and anger in a controlled, assertive way. (14)

14. Use instruction, modeling, and/or role-playing to teach the client assertive communication; if indicated, refer him/her to an assertiveness training class/group for further instruction.

10. Learn and implement problem-solving and/or conflict resolution skills to manage interpersonal problems constructively. (15)

15. Teach the client conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise); use modeling, role-playing, and behavior rehearsal to work through several current conflicts.

11. Practice using new calming, communication, conflict resolution, and thinking skills in session with the therapist and during homework exercises. (16, 17)

16. Assist the client in constructing and consolidating a client-tailored strategy for managing anger that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to their needs.

17. Use any of several techniques, including relaxation, imagery, behavioral rehearsal, modeling, role-playing, or feedback of videotaped practice in increasing challenging situations to help the client consolidate the use of his/her new anger and behavior management skills.

12. Practice using new calming, communication, conflict resolution, and thinking skills in homework exercises. (18, 19)

18. Assign the client homework exercises to help them practice newly learned calming (e.g., use "Safe and Peaceful Place Meditation" in the *Addiction Treatment Homework Planner,* 4th ed. by Finley and Lenz), assertion, conflict-resolution, or cognitive restructuring skills as needed; review and process toward the goal of consolidation.

19. Assist the client in reframing complaints into requests for positive change (or assign the exercise "Filing a Complaint" from the *Adolescent Psychotherapy Homework Planner,* 2nd ed. by Jongsma, Peterson, and McInnis or "Learning to Ask Instead of Demand" in the *Addiction Treatment Homework Planner,* 4th ed. by Finley and Lenz).

13. Parents learn and implement Parent Management Training skills to recognize and manage the problem behavior of the client. (20, 21, 22, 23, 24)

20. Use a Parent Management Training approach beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (e.g., see *Parenting the Strong-willed Child* by Forehand and Long; *Living with Children* by Patterson).

21. Teach the parents how to specifically define and identify problem behaviors, identify their own reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.

22. Teach the parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise), use of calm clear direct instruction,

time out, and other loss-of-privilege practices for problem behavior.

23. Assign the parents home exercises in which they implement and record results of implementation exercises (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner,* 2nd ed. by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.

24. Ask the parents to read parent training manuals (e.g., *Parenting Through Change* by Forgatch) or watch and process videotapes demonstrating the techniques being learned in session (see *Troubled Families—Problem Children* by Webster-Stratton).

14. Decrease the frequency and intensity of hostile, negativistic, and defiant interactions with parents/adults. (25)

25. Track the frequency and intensity of negative, hostile feelings and defiant behaviors and problem-solve solutions; implement a plan toward decreasing frequency and intensity.

15. Increase the frequency of civil, respectful interactions with parents/adults. (26, 27, 28)

26. Establish with the client the basics of treating others respectfully. Teach the principle of reciprocity, asking him/her to agree to treat everyone in a respectful manner for a one-week period to see if others will reciprocate by treating him/her with more respect; track results, problem-solve, and revisit toward increasing respectful interactions.

27. Use a therapeutic game (e.g., *The Talking, Feeling, and Doing Game* by Gardner, available from

	Creative Therapeutics, or *The Ungame* by Zakich, available from The Ungame Company) to expand the client's ability to express feelings respectfully.
	28. Videotape a family session, using appropriate portions to show the family interaction patterns that are destructive; teach family members, using role-playing, role reversal, and modeling, to implement more respectful patterns.
16. Identify and verbalize the pain and hurt of past and current life that fuels oppositional defiant behavior. (29, 30, 31)	29. Assign the client to list experiences of life that have hurt and have led to oppositional defiant behavior.
	30. Probe the patterns of violence, anger, and suspicion in the family of origin; help the client to see how these problems lead to a tendency to see people and situations as dangerous and threatening.
	31. Probe the family dynamics that led to the oppositional defiant behavior.
17. Verbalize an understanding of how anger covers feelings of hurt, guilt, or hopelessness. (32)	32. Teach the client how anger blocks the awareness of pain, discharges uncomfortable feelings, erases guilt, and places the blame for problems on someone else.
18. Verbalize an understanding of the need for and process of forgiving others, to reduce oppositional defiant behavior. (29, 33)	29. Assign the client to list experiences of life that have hurt and have led to oppositional defiant behavior.
	33. Assist the client in identifying who he/she needs to forgive, and educate him/her as to the long-term process involved in forgiveness, versus a magical single event; recommend reading material on forgiveness (e.g., *Forgive and Forget* by Smedes).

19. Recognize the role of a higher power in judging and punishing others. (34)

20. Attend and participate in AA/NA meetings. (35)

21. Develop an aftercare program that details what to do when feeling angry or frustrated. (36)

22. Complete a re-administration of objective tests of defiance of authority as a means of assessing treatment outcome. (37)

23. Complete a survey to assess the degree of satisfaction with treatment. (38)

34. Teach the client how to turn perpetrators of pain over to his/her higher power for judgment and punishment.

35. Encourage the client to actively attend Alcoholics Anonymous/ Narcotics Anonymous (AA/NA) meetings and get a sponsor.

36. Help the client to develop a list of what adaptive action he/she is going to take when he/she feels angry in recovery (e.g., calling a sponsor, being assertive rather than aggressive, taking a time out, praying to a higher power) to avoid relapse.

37. Assess the outcome of treatment by re-administering to the client objective tests of oppositional defiant behavior; evaluate the results and provide feedback to the client.

38. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	313.81	Oppositional Defiant Disorder
	312.8	Conduct Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	312.34	Intermittent Explosive Disorder
	312.30	Impulse-Control Disorder NOS
	309.4	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
	V71.02	Child or Adolescent Antisocial Behavior
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	V71.09	No Diagnosis
	_____	_____
	_____	_____

PARENT-CHILD RELATIONAL PROBLEM

BEHAVIORAL DEFINITIONS

1. Expresses parent-child relationship stress that provides an excuse for addiction and addictive behavior, which exacerbates relationship conflicts.
2. Lack of communication between parent and child.
3. Refuses to obey parent's rules or accept their limits.
4. Exhibits poor communication skills between parent and child.
5. Demonstrates a pattern of addiction and dishonesty, leading to parent-child anger and resentments.
6. Frequent arguing and a feeling of emotional distance between parent and child.
7. Has a history of substance abuse, leading to social isolation and withdrawal.
8. Displays a pattern of verbal or physical abuse by the parent toward the child.
9. Becomes involved in a peer group to the exclusion of parents and family members.
10. Lacks ability to establish and maintain meaningful, intimate family relationships.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and parent-child conflicts.
2. Terminate addictive behavior and resolve parent-child relationship conflicts.
3. Understand the relationship between addictive behavior and parent-child conflicts.
4. Learn and demonstrate healthy communication skills.
5. Decrease parent-child conflict and increase mutually supportive interaction.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the nature and history of the parent-child conflicts. (1)	1. Explore in family and individual sessions the nature and history of the client's parent-child conflicts; compare these to conflicts the parent may have had with his/her parents.
2. Verbalize the powerlessness and unmanageability that result from parent-child conflicts and addiction. (2)	2. Using a 12-step recovery program's Step One exercise, help the client to see how parent-child relational conflicts and addiction led to powerlessness and unmanageability.
3. Complete psychological testing or objective questionnaires for assessing parent-child conflict. (3)	3. Administer to the client psychological instruments designed to objectively assess parent-child relational conflict (e.g., the Parenting Stress Index [PSI], the Parent-Child Relationship Inventory [PCRI], Intra and Interpersonal Relations Scale); give the client feedback regarding the results of the assessment.

4. List times when addictive behavior led to parent-child relational conflicts. (4, 5)	4. Help the client to see how addiction has caused parent-child conflicts, and how conflicts have precipitated addictive behavior. 5. Ask the client to list instances when addictive behavior led to parent-child relationship conflicts.
5. List occasions when parent-child conflicts triggered addictive behavior. (4, 6)	4. Help the client to see how addiction has caused parent-child conflicts, and how conflicts have precipitated addictive behavior. 6. Ask the client to list occasions when parent-child conflicts triggered addictive behavior.
6. Verbalize an acceptance of responsibility for own role in parent-child relationship problems, and in choosing addictive behavior as a means of coping with relationship conflicts. (6, 7, 8)	6. Ask the client to list occasions when parent-child conflicts triggered addictive behavior. 7. Help the client to accept the responsibility for his/her role in relationship problems, and for choosing addiction as a reaction to the conflicts. 8. Confront the client's denial of responsibility for the parent-child conflict, and the client's projection of all responsibility onto others.
7. Acknowledge that the child has been the victim of abuse. (8, 9, 10, 11)	8. Confront the client's denial of responsibility for the parent-child conflict, and the client's projection of all responsibility onto others. 9. Assess the nature and severity of the client's abusive behaviors toward the child; follow through on mandatory reporting of any child abuse. 10. Facilitate the immediate protection of the child from any further abuse (e.g., notifying legal authorities of the abuse, temporary placement of the child with other family or a

friend, removal of the abusive parent from the home).

11. Refer the abusive parent to a domestic violence treatment program.

8. Identify five positive and five negative aspects of the current parent-child relationship. (12)

12. Ask the client to list five positive and five negative aspects of the parent-child relationship.

9. Each family member list the changes that he/she believes each person must make to restore the relationship. (13, 14, 15, 16)

13. Assist the client and other family members in identifying the causes for past and present conflicts between them.

14. Assign the client the task of listing the behavioral changes that he/she needs to make and the changes that he/she believes each family member needs to make to restore the relationship.

15. Assign each family member the task of listing the behavioral changes that he/she needs to make and the changes that he/she believes the other family members need to make to restore the relationship.

16. In a family session, obtain a written commitment from each member as to what behaviors each will attempt to change.

10. Initiate activities that verbally and nonverbally promote intimacy. (17, 18)

17. In a family session, facilitate a discussion of parent-child problems, and make plans to improve intimacy, nurturing, and communication.

18. Using modeling, role-playing, and behavior rehearsal, teach the family members how to show verbal and nonverbal affection toward each other (e.g., going for a walk together, sharing feelings, doing fun things together, giving

	hugs, giving each other compliments and praise).
11. Learn and demonstrate healthy communication skills. (19, 20, 21)	19. Using modeling, role-playing, and behavior rehearsal, teach the client healthy communication skills (e.g., active listening, reflecting, sharing feelings, using "I messages").
	20. Facilitate a family session with the focus on teaching and improving communication skills.
	21. Assign the client to develop a written plan as to the time, place, and amount of time that will be devoted to private, one-to-one communication with each family member each day.
12. Learn and implement Parent Management Training skills to recognize and manage challenging problem behaviors in children. (22, 23, 24, 25, 26)	22. Use a Parent Management Training approach beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior, and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (e.g., see *Parenting the Strong-Willed Child* by Forehand and Long; *Living with Children* by Patterson; and *Parenting Your Out-of-Control Teenager* by Sells).
	23. Teach the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.
	24. Teach parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for

acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise), use of clear direct instruction, time out, and other loss-of-privilege practices for problem behavior, negotiation, and renegotiation (usually with older children and adolescents). 

25. Assign parents home exercises in which they implement and record results of implementation exercises; review in session; provide corrective feedback toward improved, appropriate, and consistent use of skills. 

26. Ask parents to read parent training manuals (e.g., *Parenting Through Change* by Forgatch) or watch videotapes demonstrating the techniques being learned in session (see *Troubled Families—Problem Children* by Webster-Stratton). 

13. Make written plans to increase pleasurable activities spent by the parent and child. (27, 28)

27. Help the family to make a list of the pleasurable activities that they would like to do together; help them to make plans to become involved in at least one activity each week.

28. Assign the client to write a letter to each family member sharing how he/she feels, and suggesting pleasurable activities that they could engage in together during recovery.

14. Write a plan for meeting social and emotional needs during aftercare. (29)

29. Encourage and support the client in building new social relationships that will meet his/her emotional needs, increase satisfaction with life, replace addictive behavior, and reinforce social skills.

15. Develop a personal recovery plan that includes regular attendance at recovery groups, getting a sponsor, and any other therapy that is necessary to recover from parent-child relational conflicts and addiction. (30, 31)

16. Complete a re-administration of objective tests of parent-child conflicts as a means of assessing treatment outcome. (32)

17. Complete a survey to assess the degree of satisfaction with treatment. (33)

30. Help the client to develop a written personal recovery plan that includes attending recovery group meetings regularly, getting a sponsor, and any other therapy that is necessary to recover from parent-child relational problems and addiction.

31. Teach the client and the family about 12-step recovery groups (e.g., Al-Anon, Narcanon, Alateen).

32. Assess the outcome of treatment by re-administering to the client objective tests of parent-child relational conflict; evaluate the results and provide feedback to the client.

33. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	313.81	Oppositional Defiant Disorder
	V61.20	Parent-Child Relational Problem
	V62.81	Relational Problem NOS
	V61.21	Physical Abuse of a Child
	V61.21	Sexual Abuse of a Child
	V61.21	Neglect of a Child
	_____	_____
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Axis II:	301.7	Antisocial Personality Disorder
	301.20	Schizoid Personality Disorder
	301.81	Narcissistic Personality Disorder
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PARTNER RELATIONAL CONFLICTS

BEHAVIORAL DEFINITIONS

1. Expresses relationship stress as an excuse for addiction, which, in turn, exacerbates the relationship conflicts.
2. Lacks communication with spouse or significant other.
3. Separated from partner due to addictive behavior.
4. Reports an impending or recent divorce.
5. Has a pattern of superficial or nonexistent communication, frequent arguing, infrequent sexual enjoyment, and a feeling of emotional distance from partner.
6. Presents with a pattern of substance use leading to social isolation and withdrawal.
7. Reports a pattern of verbal and/or physical abuse present in the relationship.
8. Engages in multiple superficial relationships, often with sexual intercourse, but without commitment or meaningful intimacy.
9. Has not established and maintained meaningful, intimate interpersonal relationships.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and partner relational conflicts.
2. Terminate addiction and resolve the relationship conflicts that increase the risk of relapse.
3. Understand the relationship between addiction and partner relational conflicts.
4. Accept termination of the relationship, and make plans to move forward in life.
5. Develop the skills necessary to maintain open, effective communication, sexual intimacy, and enjoyable time with a partner.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Verbalize the powerlessness and unmanageability that result from partner relational conflicts and addiction. (1)	1. Using a 12-step recovery program's Step One exercise, help the client to see how partner relational conflicts and addiction lead to powerlessness and unmanageability.
2. Client and partner give their perspective on the nature of and causes for the relational conflicts. (2, 3)	2. Explore the client's perspective on the nature of and causes of conflicts with his/her partner. 3. In an individual or conjoint session, explore the client's partner's perspective on the nature of and causes of the conflicts between them.
3. Complete psychological testing or objective questionnaires for assessing partner relational conflicts. (4)	4. Administer to the client psychological instruments designed to objectively assess partner relational conflicts (e.g., *Partner Satisfaction Inventory, Revised, The Dyadic Adjustment*

	Scale); give the client feedback regarding the results of the assessment.
4. List instances when addiction has led to partner relational conflicts. (5, 6)	5. Help the client see how addiction has caused relationship conflicts, and how relationship conflicts have precipitated addiction. 6. Ask the client to list instances when addiction has led to relationship conflict.
5. List occasions when relationship conflicts have led to addiction. (5, 7)	5. Help the client see how addiction has caused relationship conflicts, and how relationship conflicts have precipitated addiction. 7. Ask the client to list occasions when relationship conflicts have led to addiction.
6. Verbalize an acceptance of the responsibility for own role in relationship problems, and in choosing addiction as a means of coping with relationship conflicts. (8)	8. Help the client to accept responsibility for his/her role in the relationship problems, and for choosing addiction as a reaction to the conflicts.
7. Identify the positive aspects of the relationship. (9)	9. Assess the couple's positive behaviors that facilitate relationship building.
8. Identify problems in the relationship including one's own role in the problems. (10,11)	10. Assess current, ongoing problem behaviors in the relationship, including possible abuse/neglect, substance use, and those involving communication, conflict-resolution, problem-solving difficulties. 11. Assign the couple a between sessions task recording in journals the positive and negative things about the significant other and the relationship (or assign "Positive and Negative Contributions to the Relationship: Mine and Yours" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); ask the couple not to

show their journal material to each other until the next session, when the material will be processed.

9. Make a commitment to change specific behaviors that have been identified by self or the partner. (12)

10. Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within the relationship. (13, 14, 15)

12. Process the list of positive and problematic features of each partner and the relationship; ask couple to agree to work on changes he/she needs to make to improve the relationship, generating a list of targeted changes (or assign "How Can We Meet Each Other's Needs and Desires?" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

13. Assist the couple in identifying conflicts that can be addressed using communication, conflict-resolution, and/or problem-solving skills (see "Behavioral Marital Therapy" by Holzworth-Munroe and Jacobson in *Handbook of Family Therapy* by Gurman and Knickerson [Eds.]).

14. Use behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach communication skills including assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner.

15. Assign the couple a homework exercise to use and record newly learned communication skills (or assign "Communication Skills" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz); process results in session, providing corrective feedback toward improvement.

11. Learn and implement problem-solving and conflict resolution skills. (13, 16, 17)	13. Assist the couple in identifying conflicts that can be addressed using communication, conflict-resolution, and/or problem-solving skills (see "Behavioral Marital Therapy" by Holzworth-Munroe and Jacobson in *Handbook of Family Therapy* by Gurman and Knickerson [Eds.]).
	16. Use behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach the couple problem-solving and conflict resolution skills including defining the problem constructively and specifically, brainstorming options, evaluating options, compromise, choosing options and implementing a plan, evaluating the results.
	17. Assign the couple a homework exercise to use and record newly learned problem-solving and conflict resolution skills (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma or "Identifying Proven Problem-Solving Skills" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz); process results in session.
12. Identify any patterns of destructive and/or abusive behavior in the relationship. (18, 19)	18. Assess current patterns of destructive and/or abusive behavior for each partner, including those that existed in each family of origin.
	19. Ask each partner to make a list of escalating behaviors that occur prior to abusive behavior.
13. Implement a "time out" signal that either partner may give to stop	20. Assist the partners in identifying a clear verbal or behavioral signal to

interaction that may escalate into abuse. (20, 21, 22)	be used by either partner to terminate interaction immediately if either fears impending abuse.
	21. Solicit a firm agreement from both partners that the "time out" signal will be responded to favorably without debate.
	22. Assign implementation and recording the use of the "time out" signal and other conflict resolution skills in daily interaction (or assign "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
14. Identify and replace unrealistic expectations for the relationship. (23)	23. Identify irrational beliefs and unrealistic expectations regarding relationships and then assist the couple in adopting more realistic beliefs and expectations of each other and of the relationship.
15. Increase flexibility of expectations, willingness to compromise, and acceptance of irreconcilable differences. (24)	24. Teach both partners the key concepts of flexibility, compromise, sacrifice of wants, and acceptance of differences toward increased understanding, empathy, intimacy, and compassion for each other.
16. Discuss the sexual problems that exist in the relationship and demonstrate the ability to show intimacy, verbally and nonverbally. (25, 26)	25. In a conjoint session, facilitate a discussion of the sexual problems, and list those things each partner can do to improve intimacy and communication.
	26. Using modeling, role-playing, and behavior rehearsal, teach the partners how to show verbal and nonverbal affection to each other (e.g., going for a walk together, talking intimately, holding hands, hugs, dancing, giving each other compliments and praise).
17. Participate in an evaluation to identify or rule out sexual	27. Gather from each partner a thorough sexual history to

dysfunction. (27, 28)	determine areas of strength and to identify areas of dysfunction. 28. Refer the client to a specialist for a diagnostic evaluation of sexual dysfunction (e.g., rule-out of organic and psychogenic factors), with recommendation for appropriate treatment (e.g., medication, sex therapy, surgery).
18. Commit to the establishment of healthy, mutually satisfying sexual attitudes and behavior that is not a reflection of destructive earlier experiences. (29, 30)	29. In a conjoint session identify sexual behavior, patterns, activities, and beliefs of each partner and the extended family. 30. Assist each partner in committing to attempt to develop healthy, mutually satisfying sexual beliefs, attitudes, and behavior that are independent of previous childhood, personal, or family training or experience.
19. Verbalize acceptance of the need for continued therapy to improve the relationship and to maintain gains. (31)	31. Help the couple to see the importance of continued therapy to improve the relationship and maintain gains
20. Increase the quality and frequency of healthy communication with the partner. (32, 33)	32. Assign the client to develop a written plan as to the time, place, and amount of time that will be devoted to private, one-to-one communication with partner each day. 33. Facilitate a conjoint session with the focus on improving communication skills.
21. Increase the frequency of pleasurable activities with the partner. (34)	34. Help the couple to make a list of the pleasurable activities that they would like to do together; solicit a promise from them to become involved in one activity together a week.
22. Grieve the loss of the relationship and make plans to move forward in life. (35, 36)	35. Encourage the client to share the grief of losing the significant other or spouse, and help him/her make a written plan to increase social

interaction and improve old relationships.

36. Encourage and support the client's efforts to build new social relationships.

23. Develop a personal recovery plan that includes regular attendance at recovery groups, getting a sponsor, and any other therapy necessary to recover from partner relational conflicts and addiction. (37)

37. Help the client develop a written personal recovery plan that includes regular attendance at recovery group meetings, getting a sponsor, and any other therapy necessary to recover from partner relational problems and addiction.

24. Complete a re-administration of objective tests of partner relational conflicts as a means of assessing treatment outcome. (38)

38. Assess the outcome of treatment by re-administering to the client objective tests of partner relational conflicts; evaluate the results and provide feedback to the client.

25. Complete a survey to assess the degree of satisfaction with treatment. (39)

39. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	V61.1	Partner Relational Problem
	V62.81	Relational Problem NOS
	V61.1	Physical Abuse of an Adult
	V61.1	Sexual Abuse of an Adult
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.20	Schizoid Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
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PEER GROUP NEGATIVITY

BEHAVIORAL DEFINITIONS

1. Associates with friends and relatives who are chemically dependent, and who encourage joining them in addictive behavior.
2. Has peers who are involved in the sale of illegal substances, and who encourage joining them in criminal behavior.
3. Reports that peer group is not supportive of recovery from addiction.
4. Is involved in a gang that is supportive of criminal activity and addiction.
5. States peers do not understand addiction or the need for recovery.
6. Reports that peers laugh and joke about recovery, and continue to abuse substances.
7. Peers engage in and encourage gambling and/or substance abuse.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and the negative influences of peers.
2. Understand that continuing to associate with the current peer group increases the risk for relapse.
3. Learn the skills necessary to develop a new peer group that is drug-free and supportive of working a program of recovery.
4. Attend recovery group meetings regularly, and help others who are addicted.

5. Educate family members about addiction and the need for recovery.
6. Encourage family members who are addicted to seek treatment.

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SHORT-TERM OBJECTIVES

1. Verbalize the powerlessness and unmanageability that result from peer group negativity and addictive behavior. (1)

2. Complete psychological testing or objective questionnaires for assessing the client's identification with the values of a negative peer group. (2)

3. Identify several times when peer group negativity led to addictive behavior. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Help the client to see the powerlessness and unmanageability that result from peer group negativity and addictive behavior (or assign the client to complete the Step One exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Administer to the client psychological instruments designed to objectively assess the client's identification with the values of a negative peer group (e.g., Family Environment Scale [FES]); give the client feedback regarding the results of the assessment.

3. Help the client to see the relationship between his/her peer group and addictive behavior, particularly how often the peer group encouraged the addictive behavior.

4. Assign the client to list instances when peers encouraged addictive behavior (or assign "What Do I Need and How Do I Get It?" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

4. List times when peer group negativity led to criminal activity. (5)	5. Assign the client to list times when the peer group led him/her into criminal activity.
5. Verbalize an acceptance of the need for breaking ties with the current peer group. (6, 7, 8, 9)	6. Reinforce the client's verbalized intent to break ties with the current peer group; empathize with the difficulty in leaving friends behind and making new friends who will reinforce the changes he/she is making toward sobriety (or assign "What Do Others See Changing?" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
	7. Help the client to grieve the loss of the old peer group, and to make plans to develop new friends in recovery.
	8. Help the client to understanding the reasons why continuing to associate with the current peer group increases his/her risk for relapse.
	9. Assist the client in listing the negative consequences associated with continuing ties to the current peer group.
6. Verbalize how peer group negativity and addictive behavior meet the 12-step recovery program's concept of *insanity*. (10)	10. Help the client see how peer group negativity and addiction meet the 12-step program's concept of *insane* (or assign the Step Two exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
7. List ways in which a higher power can assist in recovery from peer group negativity and addiction. (11, 12, 13)	11. Teach the client about the 12-step recovery program's concept of a higher power and how this power can restore him/her to sanity (e.g., asking a higher power for help in recovery, becoming involved in religious activities, practicing 12-step prayers).
	12. Assist the client in identifying the

ways that a higher power can assist him/her (e.g., by sending power to resist temptation, by imparting spiritual direction, by giving a feeling of acceptance).

13. Teach the client about turning problems over to a higher power each day; assign him/her to use this step at least once a day, and keep a record of using Step Three (or assign the client to complete the Step Three exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

8. Verbalize why obeying the law is essential for working a program of recovery. (5, 14)

5. Assign the client to list times when the peer group led him/her into criminal activity.

14. Teach the client about the 12-step recovery program's concept of rigorous honesty, and why obeying the law is essential in working a program of recovery.

9. Attend recovery group meetings regularly, and stay for coffee and conversation after each meeting. (15, 16)

15. Assign the client to make a written plan about how he/she plans to increase social contact with a new peer group that is positive toward recovery.

16. Encourage the client to stay for coffee and conversation after each 12-step recovery program meeting, to increase social skills and make new, positive friends.

10. Write an autobiography detailing the exact nature of the wrongs committed, and how these relate to the negative peer group and to addiction. (17)

17. Using a 12-step recovery program's Step Four inventory, assign the client to write an autobiography detailing the exact nature of his/her wrongs, and how these relate to the negative peer group and to addictive behavior.

11. Refuse to engage in addictive behavior in high-risk situations. (18, 19)

18. Using modeling, role-playing, and behavior rehearsal, teach the client how to refuse to engage in addictive behavior; practice refusal

	in high-risk situations for relapse (e.g., negative emotions, social pressure, interpersonal conflict, positive emotions, and testing personal control).
	19. Review the client's implementation of refusal skills in high-risk situations; reinforce success, and redirect for failure.
12 Meet with a temporary sponsor and make plans to attend recovery group meetings. (20)	20. Encourage and facilitate the client meeting his/her 12-step recovery program temporary sponsor, and discuss plans for recovery (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
13. Make a list of peers who are positive and peers who are negative toward recovery efforts. (21, 22)	21. Help the client to make a list of all peers who are positive or negative toward recovery (or assign the client to complete the "Building My Support Network" exercise in the *Addiction Treatment Homework Planner,* 4th ed. by Finley and Lenz).
	22. Assist the client in planning how to avoid or otherwise cope with peers who are unsupportive or critical of his/her recovery efforts.
14. Family members indicate who in the client's peer group needs to be avoided in recovery. (23)	23. In a family session, have the family members indicate which peers need to be avoided in recovery, and why.
15. Family members verbalize what each can do to assist the client in recovery. (24, 25)	24. Discuss with family members the connection between peer group negativity and addictive behavior; list the steps that the client must take to recover successfully.
	25. In a family session, review what each member can do to assist the client in recovery.
16. Complete a re-administration of objective tests of the client's	26. Assess the outcome of treatment by re-administering to the client

identification with the values of a negative peer group as a means of assessing treatment outcome. (26)

17. Complete a survey to assess the degree of satisfaction with treatment. (27)

objective tests of the client's identification with the values of a negative peer group; evaluate the results and provide feedback to the client.

27. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	312.8	Conduct Disorder
	309.4	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
	309.3	Adjustment Disorder with Disturbance of Conduct
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.82	Avoidant Personality Disorder
	_____	_____
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POSTTRAUMATIC STRESS DISORDER (PTSD)

BEHAVIORAL DEFINITIONS

1. Has experienced a traumatic event that involved actual or threatened death or serious injury and caused a reaction of intense fear or helplessness.
2. Experiences recurrent intrusive memories or dreams of the traumatic event.
3. Acts or feels as if the trauma were recurring.
4. Experiences intense distress when exposed to reminders of the trauma.
5. Avoids stimuli that trigger traumatic memories.
6. Experiences psychic numbing to avoid feelings or thoughts of the trauma.
7. Has periods of disassociation, or inability to remember parts of the trauma.
8. Reports persistent symptoms of increased autonomic arousal (e.g., difficulty sleeping, irritability, anger outbursts, difficulty concentrating, hypervigilance, exaggerated startle response).
9. Expresses verbal threats or displays physically violent behavior.
10. Demonstrates a pattern of intimate relationship, coworker, and authority conflict.
11. Engages in addictive behavior as an escape from pain that is associated with the trauma.

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LONG-TERM GOALS

1. Develop and implement effective coping skills to carry out normal responsibilities, participate constructively in relationships and bring addiction under control.
2. Maintain a program of recovery that is free of addiction and posttraumatic stress.
3. Resolve the emotional effects of the past trauma, and terminate its negative impact on current behavior.
4. Reduce the negative impact that the traumatic event has had on many aspects of life and return to the pretrauma level of functioning.
5. Understand posttraumatic stress symptoms and how they led to addiction in a self-defeating attempt to cope.
6. Terminate the destructive behaviors that serve to maintain escape and denial, while implementing behaviors that promote healing, acceptance of the past events, and responsible living.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the history and nature of PTSD symptoms. (1, 2)	1. Establish rapport with the client toward building a therapeutic alliance. 2. Assess the client's frequency, intensity, duration, and history of PTSD symptoms and their impact on functioning (e.g., use *The Anxiety Disorders Interview Schedule for the DSM-IV* by DiNardo, Brown, and Barlow).
2. Complete psychological tests designed to assess and/or track the nature and severity of PTSD symptoms. (3)	3. Administer or refer the client for administration of psychological testing to assess for the presence of strength of PTSD symptoms (e.g., MMPI-2, Impact of Events Scale,

	PTSD Symptom Scale, or Mississippi Scale for Combat Related PTSD).
3. Describe the traumatic event in as much detail as possible. (4)	4. Gently and sensitively explore the client's recollection of the facts of the traumatic incident and their emotional reactions at the time.
4. Verbalize the symptoms of depression, including any suicidal ideation. (5)	5. Assess the client's depth of depression and suicide potential and treat appropriately, taking the necessary safety precautions as indicated (see the Depression and Suicidal Ideation chapters in this *Planner*).
5. List times that PTSD symptoms led to addictive behavior and addictive behavior led to traumatic events. (6)	6. Assign the client to list times when symptoms of PTSD led to addictive behavior and when addictive behavior led to traumatic events (or assign "Coping with Addiction and PTSD or Other Anxiety Disorders" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
6. List the ways in which a 12-step program can assist in recovery from PTSD and addictive behavior. (7)	7. Teach the client about the 12-step recovery program and discuss how it can assist in his/her recovery.
7. Cooperate with an evaluation by a physician for psychotropic medication. (8, 9)	8. Assess the client's need for medication (e.g., selective serotonin reuptake inhibitors) and arrange for prescription, if appropriate.
	9. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medication on his/her level of functioning.
8. Verbalize an accurate understanding of PTSD and how it develops. (10, 11)	10. Discuss how PTSD results from exposure to trauma, results in intrusive recollection, unwarranted fears, anxiety, and a vulnerability to others negative emotions such as shame, anger, and guilt.

11. Assign the client to read psychoeducational chapters of books or treatment manuals on PTSD that explain its features and development (e.g., *Coping with Trauma* by Allen).

9. Verbalize an understanding of the rationale for cognitive behavioral treatment of PTSD. (12, 13)

12. Discuss how coping skills, cognitive restructuring and exposure help build confidence, desensitize and overcome fears, and see one's self, others, and the world in a less fearful and/or depressing way.

13. Assign the client to read about stress inoculation, cognitive restructuring and/or exposure-based therapy in chapters of books or treatment manuals on PTSD (e.g., *Reclaiming Your Life After Rape* by Rothbaum and Foa).

10. Learn and implement calming and coping strategies to manage challenging situations related to trauma. (14, 15)

14. Teach the client strategies from Stress Inoculation Training such as relaxation, breathing control, covert modeling (i.e., imagining the successful use of the strategies) and/or role playing (i.e., with therapist or trusted other) for managing fears until a sense of mastery is evident (see *Clinical Handbook for Treating PTSD* by Meichenbaum).

15. Assign the client to read about calming and coping strategies in books or treatment manuals on PTSD (e.g., *I Can't Get Over It* by Matsakis or assign "Safe and Peaceful Meditation" in the Addiction *Treatment Homework Planner,* 4th ed. by Finley and Lenz).

11. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (16, 17, 18)

16. Explore the client's schema and self-talk that mediate his/her trauma-related fears; identify and challenge biases; assist him/her in

generating appraisals that correct for the biases and build confidence.

17. Assign the client to read about cognitive restructuring in books or treatment manuals on social anxiety (e.g., *Reclaiming Your Life After Rape* by Rothbaum and Foa).

18. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives; review and reinforce success, providing corrective feedback for failure (see "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma or *Reclaiming Your Life After Rape* by Rothbaum and Foa).

12. Participate in imaginal and *in vivo* exposure to trauma-related memories until talking or thinking about the trauma does not cause marked distress. (19, 20, 21, 22)

19. Direct and assist the client in constructing a fear and avoidance hierarchy listing feared and avoided trauma-related stimuli.

20. Assign the client a homework exercise in which he/she does an exposure exercise and records responses (see "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma or *Posttraumatic Stress Disorder* by Resick and Calhoun); review and reinforce progress, problem-solve obstacles.

21. Have the client undergo imaginal exposure to the trauma by having him/her describe a traumatic experience at an increasing, but client-chosen, level of detail; repeat until associated anxiety reduces and stabilizes; record the session; have the client listen to it between sessions (see *Posttraumatic Stress*

	Disorder by Resick and Calhoun); review and reinforce progress, problem-solve obstacles.
	22. Assign the client to read about exposure in books or treatment manuals on PTSD (e.g., see *Reclaiming Your Life After Rape* by Rothbaum and Foa).
13. Learn and implement thought-stopping to manage intrusive, unwanted thoughts. (23)	23. Teach the client thought-stopping in which he/she internally voices the word "stop" and/or imagines something representing the concept of stopping (e.g., a stop sign or light) immediately upon noticing unwanted trauma or otherwise negative unwanted thoughts (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).
14. Learn and implement guided self-dialogue to manage thoughts, feelings, and urges brought on by encounters with trauma-related stimuli. (24)	24. Teach the client a guided self-dialogue procedure in which he/she learns to recognize maladaptive self-talk, challenges its biases, copes with engendered feelings, overcomes avoidance, and reinforces his/her accomplishments (see *Posttraumatic Stress Disorder* by Resick and Calhoun); review and reinforce progress, problem-solve obstacles.
15. Cooperate with eye movement desensitization and reprocessing (EMDR) technique to reduce emotional reaction to the traumatic event. (25)	25. Utilize the eye movement desensitization and reprocessing (EMDR) technique to reduce the client's emotional reactivity to the traumatic event.
16. Acknowledge the need to implement anger control techniques; learn and implement anger management techniques. (26, 27)	26. Assess the client for instances of poor anger management that has led to threats or actual violence that caused damage to property and/or injury to people.

27. Teach the client anger management techniques (see the Anger Management chapter in this *Planner*).

17. Learn and implement stress management skills, to reduce overall stress levels and craving. (28)

28. Teach the client stress management skills (e.g., relaxation exercises, physical exercise, talking about problems, going to meetings, getting a sponsor) to reduce the level of anxiety and increase a sense of mastery over the environment.

18. Implement a regular exercise regimen as a stress release technique. (29, 30)

29. Develop and encourage a routine of physical exercise for the client.

30. Recommend that the client read and implement programs from *Exercising Your Way to Better Mental Health* by Leith.

19. Sleep without being disturbed by dreams of the trauma. (31, 32)

31. Using progressive relaxation, biofeedback, or hypnosis, teach the client how to relax; assign him/her to relax twice a day for 10 to 20 minutes.

32. Monitor the client's sleep pattern and encourage use of relaxation, positive imagery, and sleep hygiene as aids to sleep (see the Sleep Disturbance chapter in this *Planner*).

20. Turn posttraumatic stress and addiction over to a higher power each day. (33, 34)

33. Teach the client about the 12-step recovery program's concept of a higher power, and how this can be used in recovery (e.g., attend regular religious activities, meet weekly with a spiritual advisor, practice regular prayer and meditation).

34. Using a 12-step recovery program's Step Three exercise, teach the client how to turn problems over to a higher power; discuss how he/she felt using the

	step with perpetrators of past painful events, reinforcing success and redirecting for failure.
21. Develop a written personal recovery plan that details the steps to follow to maintain abstinence from addictive behavior and to recover from posttraumatic stress. (35, 36)	35. Help the client to develop a personal recovery plan that includes attending recovery group meetings regularly, getting a sponsor, taking medications as directed, and follow-up visits with therapist or doctor.
	36. Assist the client in listing reasons why he/she should faithfully adhere to a recovery plan.
22. Family members verbalize what each can do to assist the client in recovery. (37, 38)	37. Discuss with family members the connection between PTSD and addictive behavior.
	38. In a family session, review what each member can do to assist the client in recovery.
23. Complete a re-administration of objective tests of PTSD as a means of assessing treatment outcome. (39)	39. Assess the outcome of treatment by re-administering to the client objective tests of PTSD; evaluate the results and provide feedback to the client.
24. Complete a survey to assess the degree of satisfaction with treatment. (40)	40. Administer a survey to assess the client's degree of satisfaction with treatment.
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DIAGNOSTIC SUGGESTIONS

Axis I:	309.81	Posttraumatic Stress Disorder
	300.14	Dissociative Identity Disorder
	300.6	Depersonalization Disorder
	300.15	Dissociative Disorder NOS
	309.xx	Adjustment Disorder
	995.52	Physical Abuse of Child (*victim*)
	995.53	Sexual Abuse of Child (*victim*)
	V61.21	Sexual Abuse of Child
	V61.10	Sexual Abuse of Adult (*by partner*)
	V62.83	Sexual Abuse of Adult (*by person other than partner*)
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

PSYCHOSIS

BEHAVIORAL DEFINITIONS

1. Exhibits bizarre content of thought (e.g., delusions of grandeur, persecution, reference, influence, control, somatic sensations, infidelity).
2. Verbalizes illogical form of thought and/or speech (e.g., loose association of ideas in speech, incoherence; illogical thinking; vague, abstract, or repetitive speech; neologisms, perseverations, clanging).
3. Reports perceptual disturbance (e.g., hallucinations, primarily auditory but occasionally visual or olfactory).
4. Demonstrates disturbed affect (e.g., blunted, none, flattened, or inappropriate).
5. Expresses lost sense of self (e.g., loss of ego boundaries, lack of identity, blatant confusion).
6. Presents with diminished volition (e.g., inadequate interest, drive, or ability to follow a course of action to its logical conclusion; pronounced ambivalence toward or cessation of goal-directed activity).
7. Experiences relationship withdrawal (e.g., withdrawal from involvement with external world and preoccupation with egocentric ideas and fantasies, feelings of alienation).
8. Demonstrates psychomotor abnormalities (e.g., marked decrease in reactivity to environment; various catatonic patterns, such as stupor, rigidity, excitement, posturing, or negativism; unusual mannerisms or grimacing).
9. Displays inability to adequately care for own physical needs, which is potentially harmful to self.
10. Presents as potentially harmful to self or others.
11. Engages in substance abuse, which exacerbates psychotic symptoms.

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LONG-TERM GOALS

1. Control or eliminate active psychotic symptoms, such that supervised functioning is positive and medication is taken consistently.
2. Significantly reduce or eliminate hallucinations and/or delusions.
3. Eliminate acute, reactive, psychotic symptoms, and return to normal functioning in affect, thinking, and relating.
4. Stabilize functioning adequate to allow treatment in outpatient setting.
5. Develop adaptive methods to cope with symptoms, and seek treatment when necessary.
6. Terminate substance abuse.

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SHORT-TERM OBJECTIVES

1. Accept and understand that distressing symptoms are due to a mental illness and to addictive behavior. (1, 2, 3)

2. Comply with examinations to evaluate the possible contribution of a medical condition (e.g., tumor, dementia). (4, 5)

THERAPEUTIC INTERVENTIONS

1. Determine if the client's psychosis is of a brief, reactive nature, or is chronic, with prodromal and reactive elements.
2. Explore the client's family history for serious mental illness and addictive behavior.
3. Evaluate the severity of the client's addiction, as well as psychotic symptoms; refer to emergency service if the client is a danger to self or others or symptom severity suggests possible inpatient care.
4. Refer to a physician for medical evaluation to rule out psychotic symptoms due to a general medical condition.
5. Perform or refer for neuropsychological testing to assess symptoms

	consistent with possible contribution of a general medical condition.
3. Complete psychological testing or objective questionnaires for assessing psychosis. (6)	6. Administer to the client psychological instruments designed to objectively assess psychosis (e.g., Minnesota Multiphasic Personality Inventory-2 [MMPI-2], Psychiatric Research Interview for Substance and Mental Disorders [PRISM]); give the client feedback regarding the results of the assessment.
4. Report a decrease in psychotic symptoms through the consistent use of psychotropic medications. (7, 8)	7. Refer the client for an immediate evaluation by a psychiatrist regarding his/her psychotic symptoms and a possible prescription for antipsychotic medication.
	8. Consult with the treating physician regarding sleep-inducing medications to provide the client and the caregivers time to regroup, relative to the current psychotic episode.
5. Report on the side effects and the effectiveness of the medications. (9, 10, 11, 12)	9. Educate the client about the use and expected benefits of psychotropic medications.
	10. Monitor the client's medication compliance and effectiveness.
	11. Review the side effects of the medications with both the client and the medical staff to identify the possible confounding influence of polypharmacy.
	12. Monitor the client for side effects of long-term use of neuroleptic medications (e.g., tardive dyskinesia, muscle rigidity, dystonia, metabolic effects such as weight gain).
6. Family, friends, and caregivers demonstrate techniques to cope	13. Educate the client's family, friends, and caregivers about the

	with the client's psychotic behaviors. (13, 14, 15)	symptoms of mental illness, particularly the nonvolitional aspects of the symptoms, and methods for addressing them. EB
		14. Role-play calm, adaptive responses to psychotic behaviors with the client's family, friends, and caregivers; train support persons to provide direct, nonreactive, calm responses to the client's psychotic behaviors rather than arguing about reality. EB
		15. Refer the family to a single- or multigroup family psychoeducational program (see *Multi-family Groups in the Treatment of Severe Psychiatric Disorders* by McFarland). EB
EB	7. Identify and understand the role of internal and environmental triggers of psychotic symptoms. (16, 17)	16. Help the client identify specific behaviors, situations, and feelings that serve as a context for symptom exacerbations. EB
		17. Help the client identify his/her emotional reactions and other consequences of psychotic symptoms toward the goal increasing his/her understanding of factors that may be maintaining symptoms (e.g., withdrawal leading to isolation and loneliness; paranoid accusations leading to negative reactions of others that falsely support the delusion). EB
EB	8. Identify current strategies used to cope with symptoms. (18)	18. Assess adaptive and maladaptive strategies, including deficit strategies, that the client is using to cope with psychotic symptoms. EB
EB	9. Learn and implement cognitive behavioral strategies that increase resistance to subsequent psychotic episodes. (19, 20, 21, 22, 23)	19. Provide or refer the client to a therapy that tailors cognitive behavioral strategies to help the client learn coping and compensation strategies for managing psychotic symptoms

(see *Treating Complex Cases: The Cognitive Behavioral Therapy Approach* by Tarrier, Wells, and Haddock).

20. Desensitize the client's fear of his/her hallucinations by allowing or encouraging him/her to talk about them, their frequency, their intensity, and their meaning (or assign "What Do You Hear and See?" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
21. Use education, modeling, role-play, reinforcement and other cognitive behavioral strategies to teach the client coping and compensation strategies for managing psychotic symptoms (e.g., calming techniques; attention switching and narrowing; realistic self-talk; realistic attribution of the source of the symptom; and increased adaptive personal and social activity).
22. Teach the client adaptive communication and social skills (see the Social Skills Deficits chapter in this *Planner*).
23. Prescribe in-session and homework assignments that allow the client to practice new skills, reality test and challenge his/her maladaptive beliefs, and consolidate a new approach to managing symptoms; process the exercises in session.

10. Verbalize an understanding of how personal stress can lead to decompensation, how to identify it, and how to manage it. (24, 25, 26, 27)

24. Help the client identify emotional indicators of stress (e.g., anxiousness, uncertainty, anger), and how they affect his/her symptoms and functioning.
25. Help the client identify physical indicators of stress (e.g., tense

	muscles, headaches, psychomotor agitation) and how they affect his/her symptoms and functioning.
	26. Teach the client stress management strategies such as relaxation, positive self-talk, problem-solving, communication skills, and lifestyle management considerations to help manage stress.
	27. Refer the client to an activity therapist for stress reduction activities (e.g., exercise programs, hobbies, or social clubs).
11. Identify the early warning signs of symptom exacerbation and decompensation. (28, 29)	28. Request that the client identify symptoms that indicate that he/she is decompensating (e.g., confused thoughts, hallucinations, delusions, irrational fear, withdrawal, etc.).
	29. Train the family, friends, and caregivers about the client's list of decompensation indicators so they can take appropriate action to get professional services for the client.
12. Decrease substance abuse as a precipitating trigger. (30, 31)	30. Encourage the client to discontinue substance use, including drugs, alcohol, nicotine, and caffeine (see the Substance Abuse/Dependence chapter in this *Planner*).
	31. Refer the client to a substance abuse treatment program.
13. Caregivers, friends, and family members report reduced stress regarding the client's behavior. (32)	32. Teach problem-solving, respite care, and assertiveness skills to assist caregivers in meeting their own needs when they feel overly stressed by the client's psychosis.
14. Verbalize the acceptance of mental illness and decreased feelings of stigmatization. (33, 34)	33. Encourage the client to express his/her feelings related to acceptance of the mental illness.
	34. Explain the nature of the psychotic process, its biochemical

	component, and its confusing effect on rational thought.
15. Attend a support group for others with severe mental illness. (35)	35. Refer the client to a support group for individuals with a mental illness with the goal of helping consolidate his/her new approach to recovery.
16. Engage in social interaction that is reality-based, coherent, and characterized by appropriate affect, subject-focused, logical, and organized. (36, 37, 38, 39)	36. Demonstrate acceptance to the client through a calm, nurturing manner, consistent eye contact, and active listening. 37. Provide supportive therapy to alleviate the client's fears and reduce feelings of alienation. 38. Encourage others to engage the client in social interaction, and to give feedback as to the appropriateness of social skills. 39. Reinforce the client for initiating appropriate social interaction with others.
17. Implement a plan for constructive activities for each day. (40, 41)	40. Prompt the client to complete basic activities of daily living (ADLs) to promote caring for his/her own basic needs; review and reinforce for progress. 41. Assign the client the task of daily preparing a list of activities that are planned; review and reinforce for progress.
18. Attend recreational therapy activities, and follow the rules of interaction while reporting feeling nonthreatened. (42)	42. Direct the client to attend recreational therapy activities that are nonthreatening, simple to master, and encourage a low level of social interaction; reinforce for success and redirect for failure.
19. Attend an occupational therapy group, and participate with actions that show initiative, logic, follow-through, and abstract reasoning. (43)	43. Direct occupational therapy activity that diverts the client from internal cognitive focus and provides for structured social interaction and a sense of accomplishment on the completion of a task.

20. Engage in an art therapy group discussion to identify feelings, enhance reality focus, and increase social contact. (44, 45)

44. Conduct an art therapy group, in which the client is encouraged to express feelings through various art media.

45. Lead a group discussion, in which the client is encouraged to share the meaning of his/her artwork.

21. Sleep in a normal pattern of 6 to 9 hours per night without agitation, fears, or disruption. (46)

46. Direct the client to sleep at expected times, and reinforce him/her for compliance.

22. Verbalize an understanding and acceptance of the need for a structured, supervised living situation after discharge for intensive treatment. (47)

47. Arrange for an appropriate level of supervised, residential care for the client.

23. Complete a re-administration of objective tests of psychosis as a means of assessing treatment outcome. (48)

48. Assess the outcome of treatment by re-administering to the client objective tests of psychosis; evaluate the results and provide feedback to the client.

24. Complete a survey to assess the degree of satisfaction with treatment. (49)

49. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	291.x	Alcohol-Induced Psychotic Disorder
	292.xx	Other (or Unknown) Substance-Induced Disorder
	295.xx	Schizophrenia
	296.xx	Major Depressive Disorder
	296.xx	Bipolar I Disorder
	297.1	Delusional Disorder
	298.8	Brief Psychotic Disorder
	295.40	Schizophreniform Disorder
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RELAPSE PRONENESS

BEHAVIORAL DEFINITIONS

1. Reports a history of multiple addiction treatment attempts and subsequent relapse.
2. Frequently expresses negative emotions, increasing the risk for continued addiction.
3. Friends or family members engage in addictive behavior.
4. Describes interpersonal conflicts, which increase the risk for relapse.
5. Reports experiencing social pressure, which encourages substance abuse.
6. Has never worked a program of recovery long enough to maintain abstinence.
7. Has a history of mental illness, increasing risk for relapse.
8. Reports many attempts at sobriety without treatment, but these have resulted in relapse.

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LONG-TERM GOALS

1. Maintain freedom from addiction without experiencing relapse.
2. Develop coping skills to use when experiencing high-risk situations and/or craving.
3. Resolve interpersonal conflicts, and learn healthy communication skills.
4. Develop a new peer group that is supportive of recovery.
5. Learn refusal skills for use when tempted into addictive behavior.

6. Practice a program of recovery that includes regular attendance at recovery group meetings, working with a sponsor, and helping others in recovery.

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SHORT-TERM OBJECTIVES

1. Write a detailed chemical use history, describing treatment attempts and the specific situations surrounding relapse. (1)
2. Complete psychological testing or objective questionnaires for assessing addiction relapse. (2)
3. Verbalize the powerlessness and unmanageability that result from addiction and relapse. (3)
4. Verbalize that continued alcohol/drug abuse meets the 12-step program concept of *insanity*. (4)

THERAPEUTIC INTERVENTIONS

1. Assign the client to write a chemical use history, describing his/her attempts at recovery and the situations surrounding relapse.
2. Administer to the client psychological instruments designed to objectively assess addiction relapse (e.g., Substance Abuse Relapse assessment [SARA]); give the client feedback regarding the results of the assessment.
3. Using a 12-step recovery program's Step One exercise, help the client to see the powerlessness and unmanageability that result from addiction and relapse (or assign the client to complete the Step One exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
4. Using a 12-step recovery program's Step Two exercise, help the client to see the insanity of his/her disease, then teach him/her that a higher power can restore him/her to sanity (or assign the client to complete the Step One exercise from *The Alcoholism &*

	Drug Abuse Patient Workbook by Perkinson).
5. Verbalize reasons why it is essential to work a daily program of recovery to maintain abstinence. (5, 6, 7)	5. Help the client to understand why he/she keeps relapsing (e.g., failure to work a daily program of recovery, failure to go to meetings, poor coping skills for high-risk situation, mental illness, interpersonal problems, poor recovery environment).
	6. Help the client to understand why is it essential to implement a daily program of recovery to maintain abstinence.
	7. Using the client's relapse history, help him/her to understand the reasons why his/her recovery program failed.
6. List ways in which a higher power can assist in recovery from addiction. (8, 9)	8. Teach the client how to use the 12-step recovery program's Step Three, and assign him/her to practice turning problems over to a higher power each day; have the client record each situation and discuss these with the primary therapist (or assign the client to complete the Step Two and Step Three exercises from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
	9. Teach the client how a higher power can assist in recovery (e.g., attending religious activities, practicing regular prayer and meditation).
7. Make a written plan to increase reinforcement when attending recovery group meetings. (10, 11, 12)	10. Probe the reasons why the client discontinues going to 12-step recovery program meetings consistently.
	11. Help the client to develop a plan that will increase the rewards obtained at recovery groups (e.g., concentrate on helping

others, go for coffee after the meeting, socialize, stick with the winners).

12. Assign the client to a 12-step recovery program contact person, and begin to attend recovery group meetings with him/her regularly; encourage both individuals to make the outing fun, rather than a boring obligation.

8. Renew commitment to abstain from the use of mood-altering drugs. (13)

13. After a review of the negative consequences of relapse, develop an abstinence contract with the client regarding the termination of the use of his/her drug (or assign "Substance Abuse Negative Impact Versus Sobriety's Positive Impact" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); process the client's feelings related to the commitment.

9. Verbalize an understanding of why relapse continues to occur. (14, 15, 16)

14. Teach the client the high-risk situations that lead to relapse (e.g., negative emotions, social pressure, interpersonal conflict, positive emotions, tests of personal control), or use a 12-step recovery program's relapse prevention exercise to help the client uncover his/her triggers for relapse (see "Relapse Triggers" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma or *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

15. Help the client to understand why he/she keeps relapsing; examine such issues as failure to work a daily program of recovery, failure to go to meetings, poor coping skills for high-risk situation, mental illness, interpersonal

problems, poor recovery environment (or assign "Identifying Relapse Triggers and Cues" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

16. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse.

10. Implement a plan to deal with each situation that represents a high risk for relapse. (17, 18)

17. Help the client to make a written plan that details the coping skills (e.g., go to a meeting, call a sponsor, call the 12-step recovery program hotline, call the counselor, talk to someone) to use when in a high-risk situation (e.g., negative emotions, social pressure, interpersonal conflict, strong positive emotions, tests of personal control); or assign "Relapse Prevention Planning" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz.

18. Review the client's implementation of coping skills for high-risk situations in his/her daily life; reinforce success and redirect for failure.

11. Identify, challenge, and replace destructive self-talk with positive, strength building self-talk. (19, 20)

19. Use cognitive therapy approaches to explore the client's schema and self-talk that weaken his/her resolve to remain abstinent; challenge the biases; assist him/her in generating realistic self-talk that correct for the biases and build resilience.

20. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives (or assign

"Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); review and reinforce success.

12. Learn and implement personal coping strategies to manage urges to lapse back into chemical use. (21)

21. Teach the client tailored coping strategies involving calming strategies (e.g., relaxation, breathing), thought-stopping, positive self-talk, and attentional focusing skills (e.g., distraction from urges, staying focused on behavioral goals of abstinence) to manage triggered urges to use chemical substances.

13. Learn and implement personal coping skills to manage common day-to-day challenges and build confidence in managing them without the use of substances. (22, 23, 24, 25, 26, 27)

22. Assess current skill in managing common everyday stressors (e.g., work, social, family role demands); use behavioral techniques (e.g., instruction, modeling, role-playing) to build social and/or communication skills to manage these challenges without the use of substances (or assign the client to complete *Overcoming Your Alcohol or Drug Problem,* 2nd ed. by Daley).

23. Teach the client adaptive assertive communication skills (e.g., active listening, using "I messages," reflecting, sharing feelings).

24. Teach the client conflict-resolution skills; using modeling, role-playing, and behavior rehearsal, have him/her practice handling conflict in high-risk situations (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

25. Using modeling, role-playing, and behavior rehearsal, teach the client how to say "no" to alcohol/drugs;

practice refusal in several high-risk situations.

26. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).

27. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships (see *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors* by Marlatt and Donovan).

14. Identify and make changes in social relationships that will support recovery. (28)

28. Review the negative influence of the client continuing his/her alcohol-related friendships ("drug buddies") and assist him/her in making a plan to develop new sober relationships including "sobriety buddies"; revisit routinely and facilitate toward development of a new social support system.

15. Identify projects and other social and recreational activities that sobriety will now afford and that will support sobriety. (29, 30)

29. Assist the client in planning social and recreational activities that are free from association with substance abuse; revisit routinely and facilitate toward development of a new set of activities (or assign the client to complete the "Relapse Prevention" exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

30. Plan household, work-related, and/or other free-time projects that can be accomplished to build the

client's self-esteem and self-concept as clean and sober.

16. Verbalize how the living situation contributes to chemical dependence and acts as a hindrance to recovery. (31)

31. Evaluate the role of the client's living situation in fostering a pattern of chemical dependence; process with the client toward identifying therapeutic changes.

17. Make arrangements to terminate current living situation and move to a place more conducive to recovery. (32)

32. Facilitate development of a plan for the client to change his/her living situation to foster recovery; revisit routinely and facilitate toward accomplishing a positive change in living situation.

18. Identify problems with intimate and family relationships that may be a hindrance to recovery. (33)

33. Assist the client in problem-solving issues in intimate or family relationships toward the goal of changes that promote recovery.

19. Cooperate with an examination by a physician to see if pharmacological intervention is warranted. (34)

34. Refer the client to a physician to examine the client, order medications as indicated, titrate medications, and monitor for side effects.

20. Take all medication as directed, and report as to the effectiveness and side effects. (35, 36)

35. Monitor the client's psychotropic medication for compliance, effectiveness, and side effects.

36. Direct the staff to administer medications as ordered by the physician and to monitor the psychotropic medications for compliance, effectiveness, and side effects.

21. Agree to enter the structured continuing-care treatment setting that is necessary to maintain abstinence. (37)

37. Help the client to decide on an aftercare placement that is structured enough to help him/her maintain abstinence (e.g., halfway house, group home, outpatient treatment, day care, partial hospitalization).

22. Develop a written personal recovery plan. (38)

38. Help the client to develop a written continuing care plan that includes honesty, attending recovery group meetings regularly, getting a sponsor, and any other treatment

that is needed to maintain abstinence; (or assign "Aftercare Plan Components" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

23. Complete a re-administration of objective tests of addiction relapse as a means of assessing treatment outcome. (39)

24. Complete a survey to assess the degree of satisfaction with treatment. (40)

39. Assess the outcome of treatment by re-administering to the client objective tests of addiction relapse; evaluate the results and provide feedback to the client.

40. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	312.8	Conduct Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	301.13	Cyclothymic Disorder
	314	Attention-Deficit/Hyperactivity Disorder
	313.81	Oppositional Defiant Disorder
	304.80	Polysubstance Dependence
	_____	_____
	_____	_____
Axis II:	301.20	Schizoid Personality Disorder
	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.82	Avoidant Personality Disorder
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SELF-CARE DEFICITS*—PRIMARY

BEHAVIORAL DEFINITIONS

1. Presents with chronic chemical dependence that has eroded motivation and discipline necessary for adequate self-care.
2. Demonstrates substandard hygiene and grooming, as evidenced by strong body odor, disheveled hair, or dirty clothing.
3. Fails to use basic hygiene techniques (e.g., bathing, brushing teeth, washing clothes).
4. Presents with medical problems due to poor hygiene.
5. Maintains poor diet due to deficiencies in cooking, meal preparation, or food selection.
6. Has poor interaction skills, as evidenced by limited eye contact, insufficient attending, and awkward social responses.
7. Has inadequate knowledge or functioning in basic skills around the home (e.g., cleaning floors, washing dishes, disposing of garbage, keeping fresh food available).
8. Reports loss of relationships, employment, or other social opportunities due to poor hygiene and/or inadequate attention to grooming.

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LONG-TERM GOALS

1. Discontinue substance abuse and increase functioning in self-care.
2. Understand the need for good hygiene and implement healthy personal hygiene practices.
3. Learn basic skills for maintaining a clean, sanitary living space.
4. Regularly shower or bathe, shave, brush teeth, care for hair, and use deodorant.
5. Experience increased social acceptance because of improved appearance and/or improved functioning in self-care.

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SHORT-TERM OBJECTIVES

1. Describe current functioning in self-care, and how this relates to substance abuse. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Request that the client prepare an inventory of positive and negative functioning regarding self-care, including the relationship between lack of self-care and substance abuse (or assign "Assessing Self-Care Deficits" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
2. Ask the client to identify a trusted individual from whom he/she can obtain helpful feedback regarding daily hygiene and cleanliness; coordinate feedback from this individual to the client.
3. Assess the client's basic nutritional knowledge and skills, usual diet, and nutritional deficiencies; refer to a dietitian, if necessary.

2. Complete or give permission for a significant other to complete a survey of the client's level of implementation of self-care skills. (4)

4. Administer to the client or a significant other an objective psychological instrument (e.g., Independent Living Scales by Loeb) to assess the client's degree of implementation of self-care skills; give the client feedback regarding the results of the assessment.

3. List five negative effects of substance abuse and of not giving enough effort to self-care. (5, 6, 7, 8)

5. Ask the client to identify two painful experiences in which rejection was experienced (e.g., broken relationships, loss of employment) due to the lack of performance of basic self-care.

6. Help the client to visualize or imagine the possible positive changes that could result from decreased substance abuse and increased attention to appearance and other aspects of self-care.

7. Review with the client the medical risks (e.g., dental problems, risk of infection, lice) that are associated with substance abuse, poor hygiene, or lack of attention to other aspects of self-care.

8. Assist the client in expressing emotions related to impaired performance in self-care (e.g., embarrassment, depression, low self-esteem).

4. Verbalize insight into the secondary gain that is associated with decreased self-care functioning. (9)

9. Reflect the possible secondary gain (i.e., less involvement in potentially difficult social situations) that is associated with decreased self-care functioning.

5. Prioritize those self-care areas upon which to focus effort and improve functioning. (2, 10, 11)

2. Ask the client to identify a trusted individual from whom he/she can obtain helpful feedback regarding daily hygiene and cleanliness; coordinate feedback from this individual to the client.

	10. Ask the client to identify or describe those self-care behaviors that are desired, but are not present in his/her current repertoire.
	11. Facilitate the client prioritizing the implementation of self-care behaviors or the learning of skills that are necessary to implement these behaviors.
6. Cooperate with a referral for an assessment of intelligence and neuropsychological deficits. (12)	12. Refer the client for an assessment of cognitive deficits (e.g., low intelligence, brain damage) that may contribute to his/her lack of attention to self-care.
7. Participate in a remediation program to teach self-care skills. (13)	13. Recommend remediation programs to the client (e.g., a self-care skill-building group, didactic group, behavior-shaping program) that is focused on removing self-care deficits.
8. Acknowledge self-care deficits as a symptom of chronic chemical dependence or mental illness. (14)	14. Reflect or interpret poor performance in self-care as an indicator of chronic chemical dependence or psychiatric decompensation; share observations with the client, with caregivers, and with other staff.
9. Stabilize, through the use of psychotropic medications, psychotic and other severe and persistent mental illness symptoms that interfere with self-care. (15, 16, 17)	15. Arrange for an evaluation of the client by a physician to determine if a prescription for psychotropic medication is warranted.
	16. Educate the client about the proper use and the expected benefits of psychotropic medication.
	17. Monitor the client for compliance with the prescribed psychotropic medication, and for its effectiveness and possible side effects.
10. Remediate the medical effects that have resulted from a history of a lack of self-care performance. (18, 19)	18. Arrange for a full physical examination of the client; encourage the physician to prescribe any necessary self-care remediation behaviors.

19. Refer the client to a dentist to determine dental treatment needs; coordinate ongoing dental treatment.

11. Implement skills that are related to basic personal hygiene on a consistent, daily basis. (20, 21, 22, 23)

20. Provide the client with written or video educational material for basic personal hygiene skills (e.g., *The Complete Guide to Better Dental Care* by Taintor and Taintor, *The New Wellness Encyclopedia* by the editors of the University of California-Berkeley).

21. Refer the client to a designated staff for one-to-one training in basic hygiene needs and techniques.

22. Conduct or refer the client to a psychoeducational group for teaching personal hygiene skills; use the group setting to help teach the client to give and receive feedback about hygiene skill implementation.

23. Encourage and reinforce the client for performing basic hygiene skills on a regular schedule (e.g., at the same time and in the same order each day).

12. Utilize a self-monitoring system to increase the frequency of regular use of basic hygiene skills. (24, 25)

24. Help the client to develop a self-monitoring program (e.g., a check-off chart for self-care needs).

25. Provide the client with regular feedback about progress in his/her use of self-monitoring to improve personal hygiene.

13. Utilize community resources to improve personal hygiene and grooming. (26, 27)

26. Review the use of community resources with the client (e.g., laundromat/dry cleaner, hair salon/barber) that can be used to improve personal appearance.

27. Coordinate for the client to tour community facilities for cleaning

	and pressing clothes, cutting and styling hair, or purchasing soap and deodorant, with an emphasis on increasing the client's understanding of this service and how it can be used.
14. Cooperate with treatment for substance abuse and/or mental illness that interferes with the ability to care for self. (28, 29, 30)	28. Assess the client for substance abuse or severe mental illness that exacerbates poor self-care performance (or assign "Relating Self-Care Deficits to My Addiction" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
	29. Refer the client to Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or other substance abuse treatment options (see the Substance Abuse/ Dependence chapter in this *Planner*).
	30. Provide integrated, coordinated mental health and substance abuse treatment services.
15. Implement basic skills for running and maintaining a home or apartment. (31, 32)	31. Facilitate family members, friends, and caregivers who are willing to train the client in basic housekeeping skills; monitor and reinforce the client's progress.
	32. Teach the client basic housekeeping skills, utilizing references such as *Mary Ellen's Complete Home Reference Book* by Pinkham and Burg or *The Cleaning Encyclopedia* by Aslett.
16. Implement basic cooking skills and eat nutritionally balanced meals daily. (33, 34)	33. Educate the client on basic cooking techniques (e.g., *The Good Housekeeping Illustrated Cookbook,* by the editors of *Good Housekeeping or How to Cook Everything* by Bittman) or refer the client to a community-based education cooking class or seminar.

34. Monitor the client's follow-through regarding a dietitian's recommendations for changes in the client's cooking and eating practices.

17. Engage in physical exercise several times per week. (18, 35, 36, 37, 38)

18. Arrange for a full physical examination of the client; encourage the physician to prescribe any necessary self-care remediation behaviors.

35. Refer the client to an activity therapist, or make recommendations regarding physical fitness activities that are available in the community or through health clubs.

36. Assist the client in setting specific exercise goals, and monitor his/her participation in exercise and physical fitness activities.

37. Provide educational material (e.g., *Fitness and Health* by Sharkey or *ACSM Fitness Book* by American College of Sports Medicine) to increase the client's knowledge of physical fitness needs.

38. Coordinate or facilitate membership for the client at a local health club or YMCA/YWCA.

18. Complete or give permission to a significant other to complete a re-administration of a survey of the client's implementation of self-care skills, as a means of assessing treatment outcome. (39)

39. Assess the outcome of treatment by re-administering to the client or a significant other an objective survey of the client's level of implementation of self-care skills; give the client feedback regarding the results of the assessment.

19. Complete a survey to assess the degree of satisfaction with treatment. (40)

40. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	297.1	Delusional Disorder
	295.xx	Schizophrenia
	295.10	Schizophrenia, Disorganized Type
	295.30	Schizophrenia, Paranoid Type
	295.90	Schizophrenia, Undifferentiated Type
	295.60	Schizophrenia, Residual Type
	295.70	Schizoaffective Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	_____	_____
	_____	_____
Axis II:	317	Mild Mental Retardation
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SELF-CARE DEFICITS*—SECONDARY

BEHAVIORAL DEFINITIONS

1. Has a history of addictive behavior and chronic mental illness, which leads to a lack of effective independent activities of daily living (IADLs; e.g., transportation, banking, shopping, use of community services, other skills necessary for living more independently).
2. Verbalizes anxiety regarding increase in IADLs.
3. Lacks knowledge of community resources to aid in recovery.
4. Fails to respond appropriately in emergency situations.
5. Chronic addiction, paranoia, psychosis, or other severe and persistent mental illness symptoms negatively affect ability to use community resources independently.
6. Lacks familiarity with daily living resources (e.g., banking, stores, other services).
7. Does not pay attention to and organize personal responsibilities, resulting in unpaid bills and/or missed appointments.
8. Fails to access community resources (e.g., 12-step groups, worship centers, libraries, recreational areas, businesses).
9. External restrictions have been placed on access to community resources due to chronic addiction and/or bizarre behaviors.
10. Has a history of allowing or expecting others to take responsibility for performing own IADLs.

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LONG-TERM GOALS

1. Develop a program of recovery and increase knowledge of community resources.
2. Timely, appropriate, and safe responses to emergency situations.
3. Participate in recovery and increase functioning independently.
4. Consistent use of available addiction recovery and/or mental health community resources.
5. Increased organization of and attention to daily routines, resulting in personal responsibilities being fulfilled.
6. Take responsibility for own IADLs to level of own potential, and develop resources for help from others.

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SHORT-TERM OBJECTIVES

1. Describe powerlessness and unmanageability over addiction and/or mental illness and over current functioning in performing IADLs and the negative affects of substance abuse. (1, 2, 3)

2. Complete or give permission for a significant other to complete a survey of the client's IADLs. (4)

THERAPEUTIC INTERVENTIONS

1. Request that the client prepare an inventory of his/her positive and negative experiences with attempting to perform IADLs while addicted (or assign "Filling in the Gaps" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
2. Ask the client to identify two areas in which he/she has experienced success in recovery and in becoming more independent in the community.
3. Solicit from the client two areas in which addiction has led to failure in becoming more independent.
4. Administer to the client or a significant other an objective survey (e.g., Independent Living

	Scales, by Loeb) to assess the client's IADLs; give the client feedback regarding the results of the assessment.
3. Identify barriers to recovery and to increasing IADLs. (3, 5, 6)	3. Solicit from the client two areas in which addiction has led to failure in becoming more independent. 5. Examine problematic IADL areas with the client, to identify any patterns of addictive behavior or cognitions that cause failure at independent functioning (or assign "Working Toward Independence" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz). 6. After obtaining the client's permission to release information, obtain feedback from family members, friends, and caregivers about the client's addiction and performance of IADLs.
4. Prioritize IADL areas upon which to focus effort and improve functioning. (1, 7, 8)	1. Request that the client prepare an inventory of his/her positive and negative experiences with attempting to perform IADLs while addicted (or assign "Filling in the Gaps" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz). 7. Ask the client to identify or describe those IADLs that are desired but not present in current repertoire. 8. Assist the client in prioritizing IADLs and the skills that must be learned to implement these IADLs.
5. Apply for Supplemental Security Income (SSI) if necessary, and agree to work with a family or mental health community advocate. (9)	9. Help the client choose a family or mental health community advocate, and apply for SSI, if necessary.

6. Participate in remediation program to teach IADL skills and recovery from addiction. (10)

7. Increase frequency and appropriateness of recovery activities and social interaction. (11, 12, 13)

8. Develop and implement a regular schedule for performance of routine IADLs and recovery from addiction. (14, 15)

9. Acknowledge IADL deficits as a symptom of chronic addiction being inadequately controlled or treated. (16, 17)

10. Recommend programs to the client (e.g., skill-building groups, 12-step meetings, token economies or behavior-shaping programs) that are focused on removing deficits of IADL performance.

11. Explore the client's anxiety regarding social contacts, participation at recovery group meetings, and increasing independence.

12. Assist the client in learning the skills necessary for using appropriate social behavior in recovery (see Social Anxiety/Skills Deficit chapter in this *Planner*).

13. Provide positive feedback and encouragement to the client's attempts to increase social interaction and participate in a program of recovery.

14. Aid the client in developing a specific schedule for completing IADLs (e.g., go to 12-step group on Thursday, arrange finances on Monday morning, go to grocery store on Tuesday).

15. Teach the client about situations in which he/she should break from his/her established routine (e.g., do banking on a different day due to holiday, do weekly cleaning one day earlier in order to attend desired social function).

16. Educate the client about the expected or common symptoms of his/her addiction (e.g., persistent intoxication or drug abuse), which may negatively impact basic IADL functioning.

17. Reflect or interpret poor performance in IADLs as an

indicator of addiction relapse; share observations with the client, caregivers, and medical staff.

10. Comply with an evaluation by a physician for psychotropic medication, and take medication as prescribed. (18, 19, 20, 21, 22)

18. Arrange for an evaluation of the client by a physician for a prescription for psychotropic medications.

19. Educate the client about the proper use and expected benefits of psychotropic medications, including naltrexone and acamprosate; model procedures for the procurement of medications, and identify a person to monitor medication compliance.

20. Monitor the client's psychotropic medication compliance and its effectiveness and possible side effects; report any significant problems to the medical staff.

21. Develop an agreement with the client regarding the level of responsibility and independence he/she must display to trigger a decrease in clinician's monitoring of medications.

22. Coordinate an agreement between the client, pharmacist, and clinician regarding circumstances that would trigger the transfer of medication monitoring back to the clinician (e.g., the client's failure to pick up monthly prescription, client trying to refill a prescription too soon).

11. Obtain necessary transportation to work, 12-step meetings, medical appointments, leisure opportunities, or other desired destinations. (23)

23. Brainstorm possible transportation resources with the client (e.g., public transportation, personal vehicle, agency resources, friends and family, walking, bicycling); encourage and reinforce the client's independent use of these resources.

12. Use public transportation in a safe, socially appropriate, and efficient manner. (24, 25, 26)

24. Familiarize the client with available public transportation options through discussion, written schedules, and accompanied use of community services.
25. Review typical expectations for using public transportation, including payment, time schedule, and social norms for behavior.
26. Ride with the client to various destinations on public transportation until he/she is adequately comfortable in doing so alone.

13. Identify, attain, and manage adequate sources of financial income. (27, 28)

27. Assist the client in identifying and attaining adequate sources of income or eligibility for welfare assistance.
28. Develop a budget with the client, based on resources and needs.

14. Use banking resources to facilitate financial independence. (29, 30, 31)

29. Review procedures for and advantages of the use of banking systems to assist the client with IADLs, including increased security, financial organization, and convenience paying bills; caution the client about hazards related to banking (e.g., credit debt, overdrawn checking account charges).
30. Coordinate a helping relationship between specific bank staff and the client; with proper permission to release information, provide information to bank staff about the client's needs and disabilities.
31. Encourage the client to use specific staff at a specific bank branch in order to develop a more personal and understanding relationship.

15. Utilize the services of a choice of stores in the community. (32, 33)

32. Familiarize the client with retail resources available in his/her area

	through a review of newspaper advertisements and a tour of the business districts in the community.
	33. Role-play situations that commonly occur while shopping at a store (e.g., getting a sponsor, asking for assistance, declining a pushy salesperson, returning a defective item); provide the client with feedback about his/her functioning in these situations.
16. Attend 12-step meetings and other support groups. (34, 35)	34. Review places, times, and locations of support groups for the client (e.g., 12-step meetings, religious groups, community agencies).
	35. Go with the client to 12-step meetings and other groups at which he/she is uncomfortable or uncertain, gradually decreasing support.
17. Identify and contact alternative resources before contacting emergency response staff. (36, 37, 38)	36. Teach the client the appropriate use of specific emergency service professionals, including their responsibilities and limitations.
	37. Provide the client with an easy-to-read list of emergency telephone numbers.
	38. Brainstorm alternative resources that are available to the client for use, instead of "nuisance" calls to emergency response staff (e.g., contact a support group member when lonely instead of going to the emergency room, contact family first if feeling ill).
18. Request assistance from others when attempting to implement IADLs. (39, 40)	39. Ask the client to identify a list of personal resources that he/she can use for assistance in carrying out IADLs (e.g., family and friends, support group members, neighbors).

40. Role-play how to approach strangers for basic assistance (e.g., asking for directions); provide feedback to the client about his/her approach, personal hygiene or dress, and how appearance and manner affect the stranger's comfort level (see the Social Anxiety/Skills Deficit chapter in this *Planner*).

19. Complete or give permission to a significant other to complete a re-administration of a survey of the client's IADLs, as a means of assessing treatment outcome. (41)

41. Assess the outcome of treatment by re-administering to the client or a significant other an objective survey of the client's IADLs; give the client feedback regarding the results of the assessment.

20. Complete or give permission to a significant other to complete a survey to assess the degree of satisfaction with treatment. (42)

42. Administer a survey to the client or significant other to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	291.2	Alcohol-Induced Persisting Dementia
	303.90	Alcohol Dependence
	304.80	Polysubstance Dependence
	297.1	Delusional Disorder
	295.xx	Schizophrenia
	295.70	Schizoaffective Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	_____	_____
	_____	_____
Axis II:	317	Mild Mental Retardation
	_____	_____
	_____	_____

SEXUAL PROMISCUITY

BEHAVIORAL DEFINITIONS

1. Engages in repeated acts of sexual intimacy with partner with whom there is no meaningful emotional or lasting social relationship.
2. Reports a preoccupation with sexual thoughts, actions, and deeds.
3. Has a history of sexually acting out that is potentially self-damaging (e.g., unprotected sex, hiring prostitutes, cruising the streets for sex, many different sexual partners).
4. Demonstrates a pattern of sexual behavior that seeks immediate gratification.
5. Engages in prostitution.
6. Lacks control over self-destructive sexual behavior.
7. Uses sexual behavior to cope or escape from stress or to reduce tension.
8. Overreacts to mildly sexually-oriented stimulation.
9. Reports a sense of tension or affective arousal before engaging in sexual behavior, and a reduction of tension after completing the sexual act.
10. Engages in illegal sexual acts with a minor.
11. Concomitant substance abuse accompanies the impulsive, emotionally detached sexual encounters.
12. Chemical dependence leads to an exchange of sex for mood-altering drugs.

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LONG-TERM GOALS

1. Maintain a program of recovery that is free from sexual promiscuity and addictive behavior.
2. Reduce the frequency of sexual promiscuity, and increase the frequency of meaningful sexual behavior.
3. Reduce thoughts that trigger sexual promiscuity, and increase self-talk that controls behavior.
4. Learn to stop, think, and plan before acting.
5. Learn stress reduction techniques to manage stress without the use of sexually promiscuous behavior.
6. Terminate substance abuse that accompanies sexual promiscuity.

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SHORT-TERM OBJECTIVES

1. Verbalize an understanding of the powerlessness and unmanageability that result from sexual promiscuity and addiction. (1)

2. Describe the history and nature of the sexual promiscuity. (2)

3. Complete psychological testing or objective questionnaires for assessing sexual promiscuity. (3)

THERAPEUTIC INTERVENTIONS

1. Help the client to understand how sexual promiscuity and addiction lead to powerlessness and unmanageability (or assign the client to complete the Step One exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Explore the client's history and nature of sexual promiscuity (or assign the "Looking Closer at My Sexual Behavior" exercise in the *Adolescent Psychotherapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis).

3. Administer to the client psychological instruments designed to objectively assess sexual promiscuity (e.g., Derogatis

	Interview for Sexual Functioning [DISF], Multiphasic Sex Inventory-II [MSI-II], Sexual Adjustment Inventory [SAI]); give the client feedback regarding the results of the assessment.
4. Identify the negative consequences of sexual promiscuity and addiction. (4, 5)	4. Assist the client in making connections between his/her sexual promiscuity and the negative consequences that he/she has experienced.
	5. Assign the client to write a list of the negative consequences that occurred because of his/her sexual promiscuity and addiction (or assign the "Connecting Sexual Behavior with Needs" exercise in the *Adolescent Psychotherapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis).
5. Identify various times when sexual promiscuity led to addictive behavior. (6)	6. Explore times when the client acted too quickly on impulses, resulting in sexually promiscuous and addictive behavior.
6. Verbalize how sexual promiscuity and addictive behavior meet the 12-step recovery program's criteria for *insanity*. (7)	7. Help the client to see that doing the same things over and over again and expecting different results meets the program's definition of *insanity* (or assign the client to complete the Step Two exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
7. Increase the frequency of reviewing behavioral decisions with a trusted friend or family member for feedback regarding the consequences before the decision is enacted. (8)	8. Conduct a session with the spouse, significant other, sponsor, or family member and the client to develop a contract for the client receiving feedback prior to engaging in sexually promiscuous acts.
8. Identify the biopsychosocial elements that have contributed to sexual promiscuity. (9)	9. Probe the client's biopsychosocial history and help him/her to see the possible causes for his/her sexual promiscuity such as family

	patterns of promiscuity, low self-esteem, sexual abuse, or mental illness (or assign "Is It Romance or Is It Fear?" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
9. Comply with a physician's evaluation regarding the necessity for psychopharmacological intervention, and take all medications as prescribed. (10, 11)	10. Refer the client to a physician for an examination, to order medication as indicated, titrate medications, and monitor for side effects.
	11. Monitor for effectiveness and side effects when the client takes prescribed medications.
10. Identify and replace thoughts that trigger impulsive sexual behavior. (12, 13)	12. Help the client to uncover dysfunctional thoughts that lead to sexual promiscuity; teach him/her to replace each one with an accurate, positive, self-enhancing, and adaptive thought.
	13. Help the client to develop a list of positive, accurate, and self-enhancing thoughts to read to himself/herself each day, particularly when feeling tense or disparaged.
11. Implement adaptive stress-reduction techniques. (14, 15)	14. Use modeling, role-playing, and behavior rehearsal to teach the client adaptive stress-reduction techniques (e.g., talking to someone about the problem, taking a time-out, calling the sponsor, going to a meeting, engaging in exercise, practicing relaxation).
	15. Teach the client relaxation techniques (e.g., progressive relaxation, self-hypnosis, biofeedback); assign him/her to relax whenever feeling tense or anxious (or assign "Learning to Self-Soothe" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

12. Implement the assertive formula, "I feel... when you…; I would prefer it if.…" (16, 17)

16. Using modeling, role-playing, and behavior rehearsal, teach the client how to use the assertive formula, "I feel _____when you _____; I would prefer it if _____" in conflict situations.

17. Review implementation of assertiveness, feelings about it, as well as the consequences of it; redirect as necessary.

13. Implement stopping, thinking, and planning before acting. (18, 19)

18. Using modeling, role-playing, and behavior rehearsal, teach the client how to use "stop, think, and plan before acting" in various current situations.

19. Review the client's use of "stop, think, and plan before acting" in day-to-day living, and identify the positive consequences; redirect as necessary.

14. Verbalize an understanding of a 12-step program's Step Three, regarding the role of a higher power and how this step can be used in recovery from sexual promiscuity and addiction. (20)

20. Teach the client how to turn his/her will and life over to the care of a higher power; discuss how this step can be beneficial in recovery from sexual promiscuity and addictive behavior (e.g., understanding God's forgiveness and grace, practicing regular prayer, turning cravings over to God).

15. Write an autobiography detailing the exact nature of wrongs that were committed, and relate each of these wrongs to sexual promiscuity. (21)

21. Assign the client to write an autobiography of the exact nature of his/her wrongs, and to relate these wrongs to sexual promiscuity and addiction.

16. Disclose any history of sexual abuse in childhood, and relate that experience to current patterns of sexual behavior. (22, 23)

22. Explore the client's history of sexual abuse.

23. Relate the client's childhood sexual abuse to his/her current pattern of sexual promiscuity; refer the client for ongoing counseling

that is focused on overcoming the effects of the sexual abuse.

17. Verbalize why a meaningful relationship is necessary for true sexual intimacy. (24)

24. Teach the client the importance of a meaningful relationship, to allow for true intimacy in a sexual encounter.

18. Identify those factors that contribute to difficulty with establishing intimate, trusting relationships. (25)

25. Explore the client's history of rejection or neglect, which may have led to an inability to form and/or maintain trusting, close, intimate relationships.

19. Identify triggers to sexual promiscuity and coping behaviors for each trigger. (26, 27)

26. Assist the client in identifying thoughts and situations that trigger urges to act out sexually.

27. Develop with the client adaptive behaviors to cope with trigger situations.

20. List personal advantages of monogamous sexual intimacy. (28)

28. Assist the client in identifying a list of personal advantages for him/her becoming monogamous in sexually intimate behavior (e.g., increased self-esteem, greater emotional intimacy, development of trust and respect from others, living within a spiritual value system, reduced health risk).

21. Develop and write out a continuing care program that includes the recovery group's meetings and any further therapy that is necessary for recovery. (29)

29. Help the client to develop an aftercare plan that includes attending recovery groups regularly, getting a sponsor, and any further therapy that is necessary to recover from sexual promiscuity and any other addictive behavior (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

22. Complete a re-administration of objective tests of sexual promiscuity as a means of assessing treatment outcome. (30)

30. Assess the outcome of treatment by re-administering to the client objective tests of sexual promiscuity; evaluate the results and provide feedback to the client.

23. Complete a survey to assess the degree of satisfaction with treatment. (31)

31. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	302.2	Pedophilia
	312.8	Conduct Disorder
	309.3	Adjustment Disorder with Disturbance of Conduct
	312.30	Impulse-Control Disorder NOS
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
	_____	_____

SOCIAL ANXIETY/SKILLS DEFICIT*

BEHAVIORAL DEFINITIONS

1. Acknowledges never having learned social skills that would decrease anxiety and increase confidence.
2. Expresses excessive fear and worry about social circumstances that has no factual or logical basis.
3. Admits to constant worry about social interactions, which prevents feeling comfortable in group meetings.
4. Tends to feel blamed by others for the slightest imperfection or mistake.
5. Reports symptoms of autonomic hyperactivity in social situations (e.g., cardiac palpitations, shortness of breath, sweaty palms, dry mouth, trouble swallowing, nausea, diarrhea).
6. Demonstrates symptoms of motor tension (e.g., restlessness, tiredness, shakiness, muscle tension).
7. Reports symptoms of hypervigilance in social settings (e.g., feeling constantly on edge, difficulty concentrating, sleep problems, irritability).
8. Uses addictive behavior in an attempt to control anxiety symptoms.
9. Lacks the necessary social skills to initiate and maintain relationships.
10. Alienates self from others due to socially inappropriate behavior.

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* Much of the content of this chapter (with minor revisions) is taken from A. E. Jongsma, Jr., and L. M. Peterson, *The Complete Adult Psychotherapy Treatment Planner, 4th Edition* (Hoboken, NJ: Wiley, 2006). Copyright © 2006 by A. E. Jongsma, Jr. and L. M. Peterson. Reprinted with permission.

LONG-TERM GOALS

1. Interact socially without excessive anxiety.
2. Develop the social skills that are necessary to reduce excessive anxiety in social situations, and terminate reliance on addiction as a coping mechanism.
3. Maintain a program of recovery that is free from excessive social anxiety and addiction.
4. Decrease thoughts that trigger anxiety, and increase positive, self-enhancing self-talk.
5. Learn the relationship between anxiety and addiction.
6. Form relationships that will enhance a recovery support system.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the history and nature of social fears and avoidance. (1, 2, 3)	1. Focus on developing a level of trust with the client; provide support and empathy to encourage the client to feel safe in expressing his/her social anxiety. 2. Assess the client's frequency, intensity, duration, and history of social fears and avoidance (e.g., *The Anxiety Disorders Interview Schedule for the DSM-IV* by DiNardo, Brown, and Barlow). 3. Assess the nature of any stimulus, thoughts, or situations that precipitate the client's social fear and/or avoidance.
2. Keep a daily journal of social anxiety rating, including the situations that cause anxious feelings and the negative thoughts that fueled social anxiety. (4)	4. Assign the client to keep a daily record of social anxiety, including a description of each situation that caused anxious feelings, the rating of anxiety, using Subjective Units

	of Distress (SUDs), and thoughts that triggered the anxiety; process the journal material, help the client uncover the dysfunctional, distorted thoughts that fueled the social anxiety.
3. Complete psychological testing or objective questionnaires for assessing social anxiety and social skills. (5)	5. Administer to the client tests designed to assess social anxiety and social skills (e.g., Liebowitz Social Anxiety Scale [LSAS], Social Phobia and Anxiety Inventory [SPAI], the Social Interaction Anxiety Scale [SIAS], the Brief Social Phobia Scale [BSPS], the Social Reticence Scale [SRS], Social Skills Inventory [SSI]); score and give feedback to the client.
4. Acknowledge the powerlessness and unmanageability that are caused by excessive social anxiety and addiction. (6, 7, 8)	6. Help the client to see how social anxiety and powerlessness over addiction have made his/her life unmanageable.
	7. Teach the client about the relationship between social anxiety and addiction (i.e., how the substance was used to treat the anxious symptoms, and why more substance use became necessary).
	8. Teach the client about the 12-step program concept of *insanity*, and help him/her to see how engaging in the same ineffective, self-defeating, and dysfunctional patterns of behavior in an attempt to overcome social anxiety and addiction is insane.
5. Cooperate with an evaluation by a physician for psychotropic medication. (9, 10)	9. Arrange for the client to be evaluated for a prescription of psychotropic medications.
	10. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the

prescribing physician at regular intervals.

6. Participate in small group therapy for social anxiety, or individual therapy if the group is unavailable. (11)

11. Enroll the client in a small (closed enrollment) group for social anxiety (see "Shyness" in the *Group Therapy Treatment Planner*, 2nd ed. by Paleg and Jongsma; "Social Anxiety Disorder" by Turk, Heimberg and Hope in *Clinical Handbook of Psychological Disorders* by Barlow [Ed.]), or individual therapy if a group cannot be formed.

7. Verbalize an accurate understanding of the vicious cycle of social anxiety and avoidance. (12, 13)

12. Educate the client about how social anxiety derives from cognitive biases that overestimate negative evaluation by others, undervalue the self, distress, and often lead to unnecessary avoidance.

13. Assign the client to read chapters of books or treatment manuals on social anxiety that reinforce in-session education on the cycle of social anxiety and avoidance, and the rationale for treatment (e.g., O*vercoming Shyness and Social Phobia* by Rapee; *Overcoming Social Anxiety and Shyness* by Butler; *The Shyness and Social Anxiety Workbook* by Antony and Swinson).

8. Verbalize an understanding of the rationale for treatment of social anxiety. (14, 15)

14. Educate the client about how cognitive restructuring and exposure serve as an arena to desensitize learned fear, build social skills and confidence, and reality-test biased thoughts.

15. Assign the client to read about cognitive restructuring and exposure-based therapy in chapters of books or treatment manuals on social anxiety (e.g., *Managing*

	Social Anxiety by Hope, Heimberg, Juster, and Turk; *Dying of Embarrassment* by Markaway, Carmin, Pollard, and Flynn).
9. Learn and implement calming and coping strategies to manage anxiety symptoms during moments of social anxiety. (16, 17)	16. Teach the client calming and attentional focusing skills (e.g., staying focused externally and on behavioral goals, muscular relaxation, evenly paced diaphragmatic breathing, ride the wave of anxiety) to manage social anxiety symptoms.
	17. Assign the client to read about calming and coping strategies in books or treatment manuals on social anxiety (e.g., O*vercoming Shyness and Social Phobia* by Rapee).
10. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (18, 19, 20)	18. Explore the client's schema and self-talk that mediate his/her social fear response, challenge the biases; assist him/her in generating appraisals that correct for the biases and build confidence.
	19. Assign the client to read about cognitive restructuring in books or treatment manuals on social anxiety (e.g., *The Shyness and Social Anxiety Workbook* by Antony and Swinson).
	20. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives; review and reinforce success, providing corrective feedback for failure (see "Restoring Socialization Comfort" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma; *The Shyness and Social Anxiety Workbook* by Antony and Swinson; O*vercoming Shyness and Social Phobia* by Rapee).

11. Undergo gradual repeated exposure to feared social situations within individual or group therapy sessions and review with group members and therapist. (21, 22, 23)

12. Undergo gradual repeated exposure to feared social situations outside of individual or group therapy sessions. (24)

13. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (25, 26)

21. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with the phobic response.

22. Select initial *in vivo* or role-played exposures that have a high likelihood of being a successful experience for the client; do cognitive restructuring within and after the exposure, use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate the exposure; review with the client and group members, if done in group (see *Social Anxiety Disorder* by Turk, Heimberg, and Hope).

23. Assign the client to read about exposure in books or treatment manuals on social anxiety (e.g., *The Shyness and Social Anxiety Workbook* by Antony and Swinson; O*vercoming Shyness and Social Phobia* by Rapee).

24. Assign the client a homework exercise in which he/she does an exposure exercise and records responses (or assign "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma; also see *The Shyness and Social Anxiety Workbook* by Antony and Swinson; O*vercoming Shyness and Social Phobia* by Rapee); review and reinforce success, providing corrective feedback toward improvement.

25. Use instruction, modeling, and role-playing to build the client's general social and/or communication skills (see *Social Effectiveness Training* by Turner, Beidel, and Cooley).

26. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).

14. Implement relapse prevention strategies for managing possible future anxiety symptoms. (27, 28, 29, 30).

27. Educate the client about the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.

28. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

29. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships.

30. Develop a "coping card" on which coping strategies and other important information (e.g., "Pace your breathing," "Focus on the task at hand," "You can manage it," and "It will go away") are written for the client's later use.

15. Report on instances when worries and anxieties were turned over to a higher power. (31, 32, 33)

31. Teach the client the benefits of turning his/her will and life over to the care of a higher power of his/her own understanding.

32. Using a Step Three exercise from a 12-step recovery program, teach the client how to turn problems, worries, and anxieties over to a higher power, and trust that the

	higher power is going to help him/her resolve the situation.
	33. Review and reinforce the client's implementation of turning social anxiety over to a higher power.
16. Relate the fears that were learned in the family of origin, or other painful experiences, to current social anxiety level. (34, 35, 36, 37)	34. Probe the client's family-of-origin history for experiences in which social anxiety was learned; help him/her relate these past events to current thoughts, feelings, and behaviors.
	35. Encourage and support the client in verbally expressing and clarifying his/her feelings that are associated with past rejection experiences, harsh criticism, abandonment, or trauma.
	36. Assign the client to read the books *Healing the Shame That Binds You* by Bradshaw and *Facing Shame* by Fossum and Mason; process key concepts with the therapist.
	37. Ask the client to write an autobiography, detailing the exact nature of his/her painful experiences, as well as wrongs toward others; then, teach him/her how to begin to forgive others and himself/herself.
17. Develop a leisure program that will increase pleasurable activities and affirm self. (38)	38. Help the client to develop a plan of engaging in pleasurable leisure activities (e.g., clubs, hobbies, church, sporting activities, social activities, games) that will increase his/her enjoyment of life, affirm himself/herself, and reduce stress.
18. Exercise at least three times a week at a training heart rate for at least 20 minutes. (39)	39. Using current physical fitness levels, increase the client's exercise by 10 percent a week, until he/she is exercising three times a week at a training heart rate for at least 20 minutes.

19. Verbally report positive outcomes of participation in social and support groups. (40, 41, 42)

40. Ask the client to attend and participate in available social and recreational activities within the treatment program and/or the community (or assign "Using My Support Network" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

41. Refer the client to a self-help group (i.e., AA, NA, Emotions Anonymous, Recovery) and to self-disclose twice in each session; process the experience.

42. Monitor, encourage, redirect, and give positive feedback to the client as he/she increases his/her interaction with others.

20. Complete a re-administration of objective tests of progress in overcoming social skills deficits and/or social anxiety as a means of assessing treatment outcome. (43)

43. Assess the outcome of treatment by re-administering to the client objective tests of social skills and/or social anxiety; evaluate the results and provide feedback to the client.

21. Complete a survey to assess the degree of satisfaction with treatment. (44)

44. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	300.23	Social Phobia
	300.4	Dysthymic Disorder
	292.89	Substance-Induced Anxiety Disorder
	300.01	Panic Disorder without Agoraphobia
	300.21	Panic Disorder with Agoraphobia
	300.02	Generalized Anxiety Disorder
	309.24	Adjustment Disorder with Anxiety
	309.28	Adjustment Disorder with Mixed Anxiety and Depressed Mood
	_____	_____
	_____	_____
Axis II:	301.0	Paranoid Personality Disorder
	301.83	Borderline Personality Disorder
	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	_____	_____
	_____	_____

SPIRITUAL CONFUSION

BEHAVIORAL DEFINITIONS

1. Verbalizes confusion about spiritual matters, leading to a negative attitude about using a higher power in recovery.
2. Upholds religious convictions that are negative toward addiction and toward a 12-step program of recovery.
3. Fears that God is angry with the client, preventing a connection with a higher power.
4. Refuses to seek conscious contact with God because of anger toward God.
5. Is actively involved in a religious system that is not supportive of a 12-step recovery program.
6. Lacks understanding of the need for a higher power.
7. Maintains spiritual beliefs that are negative toward the existence of a positive higher power.
8. Anger at God leads to a rejection of any religious system or personal spiritual development.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and spiritual confusion.
2. Resolve spiritual conflicts, allowing for a meaningful relationship with a higher power.
3. Understand the relationship between spiritual confusion and addiction.

4. Accept that a higher power can assist in relieving addiction.
5. Develop a concept of a higher power that is loving and supportive to recovery.
6. Learn the difference between religion and spirituality.
7. Learn how to pray and meditate as a means of making conscious contact with the higher power.

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SHORT-TERM OBJECTIVES

1. Describe the thoughts and feelings associated with the role of spirituality in personal life. (1)
2. Complete psychological testing or objective questionnaires for assessing spiritual confusion. (2)
3. Verbalize the powerlessness and unmanageability that result from spiritual confusion and addictive behavior. (3)
4. Verbalize an understanding of how spiritual confusion contributed to

THERAPEUTIC INTERVENTIONS

1. Explore the client's spiritual journey, religious training, thoughts, and feelings toward a higher power, and current spiritual practices (or assign "My History of Spirituality" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).
2. Administer to the client psychological instruments designed to objectively assess spiritual confusion (e.g., Spiritual Well-Being Scale [SWBS]); give the client feedback regarding the results of the assessment.
3. Help the client to accept that he/she is powerless over spiritual confusion and addictive behavior, and that his/her life is unmanageable (or assign the client to complete the Step One exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
4. Probe the client's history of spiritual confusion, and show

addictive behavior and how addiction led to spiritual confusion. (4, 5, 6)	him/her how this confusion contributed to addiction and a negative attitude toward recovery. 5. Help the client to identify how addiction led to spiritual confusion. 6. Help the client to see the *insanity* of his/her spiritual confusion and addictive behavior (or assign the client to complete the Step Two exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
5. Verbalize how spiritual confusion leads to a negative attitude toward working a 12-step program of recovery. (7)	7. Show the client how negative attitudes toward spiritual matters make recovery difficult.
6. Verbalize an understanding of the 12-step recovery program's concept of "God as we understand Him." (8)	8. Teach the client about the 12-step recovery program's concept of "God as we understand Him," and how this relates to his/her spiritual confusion (or assign "Understanding Spirituality" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
7. Verbalize how many different religions and cultures can work in a 12-step program of recovery. (9)	9. Teach the client how many different religions and cultures can implement a similar 12-step program of recovery.
8. Verbalize an understanding of a higher power's grace and willingness to forgive. (10, 11, 12)	10. Teach the client that the higher power will forgive him/her for the wrongs that he/she has committed. 11. Assign the client to read books on the process of forgiveness (e.g., *Forgive and Forget* by Smedes). 12. Assign the client to read *Addiction and Grace* by May; process key ideas.
9. List ways in which a higher power can assist in recovery from spiritual confusion and addiction. (13)	13. Teach the client about the importance of a higher power in a 12-step program, and list many ways that a higher power can assist

	him/her (e.g., attend regular religious activities, speak weekly with a spiritual advisor, practice regular prayer and meditation).
10. Verbalize an understanding of the concept of God's plan. (14)	14. Assign the client to read page 449 in the Alcoholics Anonymous *Big Book;* then, teach him/her how everything that happens in the world is a part of God's good plan.
11. Verbalize the need to begin a spiritual journey, as outlined in the 12 steps. (15, 16, 17)	15. Arrange for the client to meet a clergyperson who is familiar with 12-step recovery programs, and encourage the client to share his/her thoughts and feelings about a higher power.
	16. Arrange for the client to meet with a contact person or temporary sponsor, and discuss the 12-step recovery program, spiritual confusion, and addiction.
	17. Assign the client to read "How It Works" in the Alcoholics Anonymous *Big Book* and to discuss the three pertinent ideas that are outlined at the end of the chapter: (1) "We were alcoholic and could not manage our own lives"; (2) "Probably no human power could have relieved our alcoholism"; and (3) "God could and would have if He were sought."
12. Make a written plan to continue a spiritual journey as outlined in the 12 steps. (18)	18. Using the 12 steps as a guide, help the client to make a written plan to continue his/her spiritual journey.
13. Write a letter to a higher power, sharing feelings and asking for specific needs in recovery. (19)	19. Assign the client to write a letter to a higher power, sharing how he/she thinks and feels and asking for what he/she wants to aid him/her in recovery; process the content of the letter.
14. Express a decision to turn own will and life over to a higher power, as it is understood. (20)	20. Teach the client how to turn problems over to a higher power.

15. Practice prayer and meditation at least once a day. (21, 22, 23)

21. Assign the client to read Chapter 11 in AA's *Twelve Steps and Twelve Traditions*. Teach the client how to pray (talk to God) and meditate (listen for God); then, assign him/her to pray and meditate at least once each day.

22. Assign the client to keep a prayer journal, writing down his/her prayers and new insights gained about the higher power's will for his/her life.

23. Assign the client to ask God to come into his/her life each day and then ask, "God, what is the next step in my relationship with you?" Have the client write down each insight that he/she has gained from God, and share these with the primary therapist.

16. Develop a written personal recovery plan. (24)

24. Help the client to develop a personal recovery plan that includes regular attendance at recovery groups, getting a sponsor, helping others in recovery, and any other treatment that is necessary to recover from spiritual confusion and addiction (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).

17. Family members verbalize what each can do to assist the client in recovery. (25, 26)

25. Discuss with family members the connection between spiritual confusion and addictive behavior; outline the steps the client must take to successfully recover.

26. In a family session, review what each member can do to assist the client in recovery.

18. Complete a re-administration of objective tests of spiritual

27. Assess the outcome of treatment by re-administering to the client

confusion as a means of assessing treatment outcome. (27)

19. Complete a survey to assess the degree of satisfaction with treatment. (28)

objective tests of spiritual confusion; evaluate the results and provide feedback to the client.

28. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	V62.89	Religious or Spiritual Problem
	V62.4	Acculturation Problem
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	_____	_____

SUBSTANCE ABUSE/DEPENDENCE

BEHAVIORAL DEFINITIONS

1. Demonstrates a maladaptive pattern of substance use, manifested by increased tolerance and withdrawal.
2. Fails to stop or cut down use of mood-altering drug once started, despite the verbalized desire to do so and the negative consequences continued use brings.
3. Presents with blood work (e.g., elevated liver enzymes, electrolyte imbalance) and physical indicators (e.g., stomach pain, high blood pressure, malnutrition) that reflect the results of a pattern of heavy substance use.
4. Denies that chemical dependence is a problem, despite feedback from significant others that the use of the substance is negatively affecting them and others.
5. Experiences frequent blackouts when using.
6. Continues substance use despite knowledge of experiencing persistent physical, legal, financial, vocational, social, and/or relationship problems that are directly caused by the use of the substance.
7. Demonstrates increased tolerance for the drug, as there is the need to use more to become intoxicated or to recall the desired effect.
8. Exhibits physical withdrawal symptoms (e.g., shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, depression) when going without the substance for any length of time.
9. Has a history of arrests for addiction-related offenses (e.g., driving under the influence [DUI], minor in possession [MIP], assault, possession/delivery of a controlled substance, shoplifting, breaking and entering [B&E]).
10. Reports suspension of important social, recreational, or occupational activities because they interfere with using.

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LONG-TERM GOALS

1. Accept the powerlessness and unmanageability over mood-altering substances, and participate in a recovery-based program.
2. Establish a sustained recovery, free from the use of all mood-altering substances.
3. Establish and maintain total abstinence, while increasing knowledge of the disease and the process of recovery.
4. Acquire the necessary 12-step skills to maintain long-term sobriety from all mood-altering substances, and live a life free of substance abuse.
5. Improve quality of life by maintaining an ongoing abstinence from all mood-altering chemicals.

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SHORT-TERM OBJECTIVES

1. Cooperate with medical assessment and an evaluation of the necessity for pharmacological intervention. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Refer the client to a physician to perform a physical examination (include tests for HIV, hepatitis, and sexually transmitted diseases), assess the need for psychotropic medication for any mental/emotional comorbidities, and discuss the use of acamprosate (Campral), naltrexone (Revia,

	Vivitrol), or disulfiram (Antabuse) where applicable.
	2. Refer the client to a pharmacology-based treatment/recovery program (e.g., acamprosate, naltrexone), where applicable.
2. Take prescribed medications as directed by the physician. (3, 4)	3. Physician will monitor the effectiveness and side effects of medication, titrating as necessary.
	4. Staff will administer prescribed medications and monitor for effectiveness and side effects.
3. Report acute withdrawal symptoms to the staff. (5)	5. Assess and monitor the client's condition during withdrawal, using a standardized procedure (e.g., Narcotic Withdrawal Scale) as needed.
4. Complete psychological testing or objective questionnaires for assessing substance dependence. (6)	6. Administer to the client psychological instruments designed to objectively assess substance dependence (e.g., Substance Use Disorders Diagnostic Schedule-IV [SUDDS-IV], Substance Abuse Subtle Screen Inventory-3 [SASS-3]); give the client feedback regarding the results of the assessment.
5. Provide honest and complete information for a chemical dependence biopsychosocial history. (7)	7. Complete a thorough family and personal biopsychosocial history that has a focus on addiction (e.g., family history of addiction and treatment, other substances used, progression of substance abuse, consequences of abuse).
6. Attend didactic sessions and read assigned material in order to increase knowledge of addiction and the process of recovery. (8, 9, 10, 11)	8. Assign the client to attend a chemical dependence didactic series to increase his/her knowledge of the patterns and effects of chemical dependence; ask him/her to identify several key points attained from each didactic

	and process these points with the therapist.
	9. Assign the client to read a workbook describing evidence-based treatment approaches to addiction recovery (e.g., *Overcoming Your Alcohol or Drug Problem*, 2nd ed. by Daley and Marlatt); use the readings to reinforce key concepts and practices throughout therapy.
	10. Assign the client to read material on addiction (e.g., *Willpower's Not Enough* by Washton, *The Addiction Workbook* by Fanning, or *Alcoholics Anonymous*); process key points gained from the reading.
	11. Require the client to read the book *Narcotics Anonymous* and gather five key points from it to process with the therapist.
7. Attend group therapy sessions to share thoughts and feelings associated with, reasons for, consequences of, feelings about, and alternatives to addiction. (12, 13)	12. Assign the client to attend group therapy.
	13. Direct group therapy that facilitates the client sharing of causes for, consequences of, feelings about, and alternatives to addiction.
8. Verbally admit to powerlessness over mood-altering substances. (14)	14. Assign the client to complete a Narcotics Anonymous (NA) Step One paper admitting to powerlessness over mood-altering chemicals, and present it in group therapy or to therapist for feedback (see *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
9. List and discuss negative consequences resulting from or exacerbated by substance dependence. (15, 16, 17)	15. Ask the client to make a list of the ways chemical use has negatively impacted his/her life (or assign "Substance Abuse Negative Impact Versus Sobriety's Positive Impact" in the *Adult Psycho-*

	therapy Homework Planner, 2nd ed. by Jongsma); process the list in individual or group sessions.
	16. Confront the client's use of denial to minimize the severity of and negative consequences of substance abuse.
	17. Using the biopsychosocial history and the client's list of negative consequences of substance abuse, assist him/her in understanding the need to stay in treatment.
10. Verbalize recognition that mood-altering chemicals were used as the primary coping mechanism to escape from stress or pain, and resulted in negative consequences. (18)	18. Explore how addiction was used to escape from stress, physical and emotional pain, and boredom; confront the negative consequences of this pattern.
11. List and discuss the negative emotions that were caused by or exacerbated by substance dependence. (19)	19. Probe the client's sense of shame, guilt, and low self-worth that has resulted from addiction and its consequences.
12. List and discuss reasons to work on a plan for recovery from addiction. (20)	20. Assign the client to write a list of reasons to be abstinent from addiction (or assign "Making Change Happen" or "A Working Recovery Plan" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
13. List lies used to hide substance dependence. (21, 22)	21. Help the client see the dishonesty that goes along with addiction; ask him/her to list lies told to hide substance use (or assign the client to complete the "Honesty" exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
	22. Teach the client why honesty is essential to recovery.
14. Verbalize ways a higher power can assist in recovery. (23)	23. Teach the client about the AA concept of a higher power and how this can assist in recovery

(e.g., God can help with chronic pain or craving, regular prayer and meditation can reduce stress; or assign the client to complete the Step Two and Step Three exercises from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

15. Identify and accept the need for substance abuse treatment. (24)

24. Conduct Motivational Interviewing to assess the client's stage of preparation for change; intervene accordingly, moving from building motivation, through strengthening commitment to change, to participation in treatment (see *Motivational Interviewing,* 2nd ed. by Miller and Rollnick).

16. Identify realistic goals for substance abuse recovery. (25, 26, 27)

25. Assign the client to meet with an AA/NA member who has been working the 12-Step program for several years and find out specifically how the program has helped him/her to stay sober; afterward, process the meeting.

26. Request that the client write out basic treatment expectations (e.g., physical changes, social changes, emotional needs) regarding sobriety, and process these with the clinician.

27. Emphasize the goal of substance abuse recovery and on the need for sobriety, despite lapses or relapses.

17. Verbalize a commitment to abstain from the use of mood-altering drugs. (28)

28. Develop an abstinence contract with the client regarding the termination of the use of his/her drug; process the client's feelings related to the commitment.

18. Identify and make changes in social relationships that will support recovery. (29)

29. Review the negative influence of the client continuing his/her alcohol-related friendships ("drug

	buddies") and assist him/her in making a plan to develop new sober relationships including "sobriety buddies"; revisit routinely and facilitate toward development of a new social support system.
19. Identify projects and other social and recreational activities that sobriety will now afford and that will support sobriety. (30, 31)	30. Assist the client in planning social and recreational activities that are free from association with substance abuse; revisit routinely and facilitate toward development of a new set of activities.
	31. Plan household, work-related, and/or other free-time projects that can be accomplished to build the client's self-esteem and self-concept as clean and sober.
20. Verbalize how the living situation contributes to chemical dependence and acts as a hindrance to recovery. (32)	32. Evaluate the role of the client's living situation in fostering a pattern of chemical dependence; process with the client toward identifying therapeutic changes.
21. Make arrangements to terminate current living situation and move to a place more conducive to recovery. (33)	33. Facilitate development of a plan for the client to change his/her living situation to foster recovery; revisit routinely and facilitate toward accomplishing a positive change in living situation.
22. Identify the positive impact that sobriety will have on intimate and family relationships. (34)	34. Assist the client in identifying positive changes that will be made in family relationships during recovery.
23. Agree to make amends to significant others who have been hurt by the life dominated by substance abuse. (35, 36)	35. Discuss the negative effects the client's substance abuse has had on family, friends, and work relationships and encourage a plan to make amends for such hurt.
	36. Elicit from the client a verbal commitment to make initial amends now to key individuals and further amends later or if working Steps Eight and Nine of

an AA program (see *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

24. Participate in behavioral marital or family therapy to learn and implement ways to improve relations, resolve conflicts, solve problems, and communicate effectively. (37)

37. Refer or provide behavioral couples or family therapy (see the Partner Relational Conflict or Parenting chapters in this *Planner*).

25. Learn and implement personal coping strategies to manage urges to lapse back into chemical use. (38)

38. Teach the client tailored coping strategies involving calming strategies (e.g., relaxation, breathing), thought-stopping, positive self-talk, and attentional focusing skills (e.g., distraction from urges, staying focused on behavioral goals of abstinence) to manage triggered urges to use chemical substances.

26. Identify, challenge, and replace destructive self-talk with positive, strength building self-talk. (39, 40)

39. Use cognitive therapy approaches to explore the client's schema and self-talk that weaken his/her resolve to remain abstinent; challenge the biases; assist him/her in generating realistic self-talk that correct for the biases and build resilience.

40. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); review and reinforce success.

27. Participate in gradual repeated exposure to triggers of urges to lapse back into chemical substance use within individual or group therapy sessions and between them; review with group members and therapist. (41, 42)

41. Direct and assist the client in construction of a hierarchy of urge-producing cues to use substances (or assign "Identifying Relapse Triggers and Cues" or "Relapse Prevention Planning" in the *Addiction Treatment Homework Planner*, 4th ed. by

Finley and Lenz).

42 Select initial *in vivo* or role-played cue exposures that have a high likelihood of being a successful experience for the client; facilitate coping and cognitive restructuring within and after the exposure, use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate the exposure, review with the client and group members, if done in group.

28. Learn and implement personal skills to manage common day-to-day challenges and build confidence in managing them without the use of substances. (43, 44)

43. Assess current skill in managing common everyday stressors (e.g., work, social, family role demands); use behavioral techniques (e.g., instruction, modeling, role-playing) to build social and/or communication skills to manage these challenges without the use of substances.

44. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).

29. Learn and implement pain management techniques as an alternative to coping through substance use. (45)

45. Teach or refer client to a pain management program to learn alternatives to substance use for managing pain (see the Chronic Pain chapter in this *Planner*).

30. Implement relapse prevention strategies for managing possible future situations with high-risk for relapse. (46, 47, 48, 49, 50)

46. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse.

47. Using a 12-step recovery

program's relapse prevention exercise, help the client uncover his/her triggers for relapse (see *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

48. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

49. Request that the client identify feelings, behaviors, and situations that place him/her at a higher risk for substance abuse (or assign "Relapse Triggers" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

50. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships (or assign "Aftercare Plan Components" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

31. Structure time and increase self-esteem by obtaining employment. (51)

51. Refer the client to a supported employment program, or coach the client on preparing for employment, searching for a job, and maintaining employment (see the Occupational Problems chapter in this *Planner*).

32. Verbalize that there are options to substance use in dealing with stress and in finding pleasure or excitement in life. (52, 53, 54)

52. Teach the client the importance of getting pleasure out of life without using mood-altering substances.

53. Assign the client in developing a list of pleasurable activities (see *Inventory of Rewarding Activities* by Birchler and Weiss); assign engagement in selected activities daily.

54. Encourage the client to establish a

daily routine of physical exercise to build body stamina, self-esteem, and reduce depression (see *Exercising Your Way to Better Mental Health* by Leith).

33. Verbalize the results of turning problems over to God each day. (55)

55. Using a Step Three exercise, teach the client about the recovery concept of "turning it over"; then assign turning over problems to a higher power each day; ask the client to record the event and discuss the results.

34. Complete a re-administration of objective tests of substance abuse/dependence as a means of assessing treatment outcome. (56)

56. Assess the outcome of treatment by re-administering to the client objective tests of substance abuse/dependence; evaluate the results and provide feedback to the client.

35. Complete a survey to assess the degree of satisfaction with treatment. (57)

57. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	305.60	Cocaine Abuse
	305.30	Hallucinogen Abuse
	305.90	Inhalant Abuse
	305.50	Opioid Abuse
	305.90	Phencyclidine Abuse
	305.40	Sedative, Hypnotic, or Anxiolytic Abuse
	303.90	Alcohol Dependence
	305.20	Cannabis Abuse
	305.70	Amphetamine Abuse
	305.00	Alcohol Abuse
	304.40	Amphetamine Dependence
	304.30	Cannabis Dependence
	304.20	Cocaine Dependence
	304.50	Hallucinogen Dependence
	304.60	Inhalant Dependence
	304.00	Opioid Dependence
	304.90	Phencyclidine Dependence
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
	304.80	Polysubstance Dependence
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SUBSTANCE-INDUCED DISORDERS

BEHAVIORAL DEFINITIONS

1. Experiences memory impairment (amnestic disorder) that persists beyond expected period of substance intoxication or withdrawal effects.
2. Experiences memory impairment and cognitive disturbance (dementia) that persist beyond expected period of substance intoxication or withdrawal effects.
3. Lacks clear awareness of the environment, deficient in ability to focus attention, has memory dysfunction, language and/or perceptual disturbance (delirium) that developed during or shortly after substance intoxication or withdrawal.
4. Experiences hallucinations or delusions that persist beyond expected period of substance intoxication or withdrawal effects.
5. Exhibits depressed mood that developed during or shortly after substance intoxication or withdrawal.
6. Exhibits markedly expansive mood that developed during or shortly after substance intoxication or withdrawal.
7. Reports prominent anxiety, panic attacks, or obsessions that developed during or shortly after substance intoxication or withdrawal.
8. Reports sleep disturbance that developed during or shortly after substance intoxication or withdrawal.
9. Presents with sexual dysfunction that developed during or shortly after substance intoxication or withdrawal.
10. Exhibits psychiatric signs and symptoms secondary to substance abuse or dependence.

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LONG-TERM GOALS

1. Learn the importance of working a 12-step program, and maintain a program of recovery from addiction and substance-induced disorders.
2. Restore normal sleep pattern, improve long- and short-term memory, and maintain abstinence from addiction.
3. Recover clear memory and an awareness of environment, realistic perceptions, coherent communication, focused attention, and abstain from addiction.
4. Reduce anxiety symptoms significantly, and abstain from addictive behavior.
5. Expansive mood returns to normal level, depressed mood elevated to normal functioning, and abstinence from addiction is maintained.
6. Participate in medical management of substance-induced disorder and addiction.
7. Psychiatric signs and symptoms secondary to substance abuse return to normal levels.

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SHORT-TERM OBJECTIVES

1. Verbalize an understanding that the signs and symptoms of the substance-induced disorder are caused by chemical dependence. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Welcome the client to treatment and explain that he/she is in a safe place; encourage him/her to stay in treatment long enough to begin recovery.
2. Gather information regarding the client's recent substance abuse behavior and history of chemical dependence.
3. Teach the client about his/her substance-induced disorder, and directly relate signs and symptoms to chemical abuse; indicate that the symptoms will ameliorate if the client remains abstinent.

2. Complete psychological testing or objective questionnaires for assessing substance-induced disorders. (4)	4. Administer to the client psychological instruments designed to objectively assess substance-induced disorders (e.g., Beck Depression Inventory [BDI], Beck Anxiety Inventory [BAI], Clinical Institute Withdrawal Scale [CIWS], Narcotics Withdrawal Scale [NWS], Mental Status Examination, Cognitive Screening Capacity Examination, etc.); give the client feedback regarding the results of the assessment.
3. Report to the staff any thoughts of causing harm to self or others. (5)	5. Assess the client's potential for harm to self or others, and take precautionary steps if needed; encourage reporting to the staff any future thoughts of causing harm to self or others.
4. Verbalize feelings that surround substance-induced disorder and addiction. (6)	6. Encourage the client to share the feelings that surround substance-induced disorder and addiction.
5. Submit to a physician's physical examination to assess bodily functions and the need for psychotropic medications. (7)	7. Refer the client to a physician to examine the client, write treatment orders as indicated, titrate medications, and monitor for effectiveness and side effects.
6. Take prescribed medications as directed by the physician, and report symptoms and side effects to the medical staff. (8)	8. Direct the staff to carry out orders as directed by the physician and to monitor the client's symptoms and the effectiveness and side effects of the prescribed medication.
7. Intake fluids and nourishment as indicated by the medical staff. (9)	9. Encourage the client to take fluids and nourishment as ordered by the physician.
8. Stay with a staff member during severe symptoms of substance-induced disorder, intoxication, or withdrawal. (10)	10. Assign a staff member to stay with the client during severe substance-induced disorder, intoxication, or withdrawal.
9. Reduce environmental stimulation to decrease excessive anxiety, perceptual disturbances, and irritability. (11)	11. Adjust the client's environment until there is minimal stimulation that might exacerbate excessive anxiety, perceptual disturbances, and irritability.

10. Talk with a treatment peer that is further along in the program, and discuss plans for recovery. (12)
11. Verbalize the need for further treatment and develop a written plan to address substance-induced disorder and addiction. (13, 14)
12. Family members verbalize an understanding of the connection between substance-induced disorder and addiction. (15, 16)
13. Complete a re-administration of objective tests of substance-induced disorders as a means of assessing treatment outcome. (17)
14. Complete a survey to assess the degree of satisfaction with treatment. (18)

12. Ask treatment peers to encourage the client during the early stages of recovery.
13. Teach the client about 12-step recovery, and encourage him/her to stay in treatment.
14. Help the client develop a written plan to treat his/her substance-induced disorder and addiction (or assign "Planning Aftercare" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
15. In a family session, explain the connection between substance-induced disorder and addictive behavior.
16. Help the client to list three things that each family member can do to assist him/her in recovery.
17. Assess the outcome of treatment by re-administering to the client objective tests of substance-induced disorder; evaluate the results and provide feedback to the client.
18. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	291.0	Alcohol Intoxication Delirium
	291.0	Alcohol Withdrawal Delirium
	291.2	Alcohol-Induced Persisting Dementia
	291.1	Alcohol-Induced Persisting Amnestic Disorder
	291.5	Alcohol-Induced Psychotic Disorder, with Delusions
	291.3	Alcohol-Induced Psychotic Disorder, with Hallucinations
	291.89	Alcohol-Induced Mood Disorder
	291.89	Alcohol-Induced Anxiety Disorder
	291.8	Alcohol-Induced Sexual Dysfunction
	291.8	Alcohol-Induced Sleep Disorder
	292.81	Other Substance-Induced Delirium
	292.82	Other Substance-Induced Persisting Dementia
	292.xx	Other Substance-Induced Persisting Amnesia
	292.xx	Other Substance-Induced Psychotic Disorder
	292.84	Other Substance-Induced Mood Disorder
	292.89	Other Substance-Induced Anxiety Disorder
	292.89	Other Substance-Induced Sexual Dysfunction
	292.89	Other Substance-Induced Sleep Disorder
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SUBSTANCE INTOXICATION/WITHDRAWAL

BEHAVIORAL DEFINITIONS

1. Demonstrates cognitive, behavioral, or emotional changes (e.g., alcohol on breath, belligerence, mood disorder, cognitive impairment, impaired judgment, slurred speech, ataxia) shortly after ingestion or exposure to a substance.
2. Presents with abnormal autonomic reactivity (e.g., elevated or decreased vital signs, tachycardia, dilated or constricted pupils, diaphoresis, flushed face) subsequent to the introduction of a mood-altering substance into the body.
3. Admits to recently abusing a mood-altering chemical.
4. Presents with urine, blood screen, or breathalyzer results that indicate recent substance use.
5. Exhibits psychological symptoms caused by substance withdrawal (e.g., irritability, anxiety, anger, emotional lability, depression, hallucinations, delusions).
6. Reports that intoxication or withdrawal symptoms cause significant impairment in work, school, or play.
7. Experiences a preoccupation with strong cravings, leaving treatment and using mood-altering chemicals.

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LONG-TERM GOALS

1. Stabilize condition medically, behaviorally, emotionally, and cognitively, and return to functioning within normal parameters.
2. Recover from substance intoxication/withdrawal, and participate in a chemical dependency assessment.
3. Understand the severity of and reasons for the substance use, and enter a program of recovery.
4. Comply with assessments of substance intoxication and withdrawal.
5. Enter a program of recovery necessary to bring addiction under control.
6. Understand the extent of the danger to self and others when intoxicated.
7. Comply with all physician orders.
8. Keep medical staff informed of withdrawal symptoms.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Verbalize an acceptance of the need to be in a safe place to recover from substance intoxication/withdrawal. (1, 2)	1. Welcome the client to the treatment setting; explain substance intoxication and the procedures that will be used to arrest symptoms. 2. Teach the client the importance of staying in treatment to recover from substance intoxication and possible withdrawal.
2. Complete psychological testing or objective questionnaires for assessing intoxication/withdrawal. (3)	3. Administer to the client psychological instruments designed to objectively assess substance intoxication/withdrawal (e.g., Clinical Institute of Withdrawal Scale, Narcotic Withdrawal Scale); give the client feedback regarding the results of the assessment.

3. Verbalize an agreement to cooperate with the medical management of substance intoxication/withdrawal. (4)	4. Inform the client of what he/she can expect during intoxication and withdrawal, and encourage him/her to cooperate with medical management; ask him/her to sign a consent-to-treat form.
4. Sign a release of information form to allow significant others to be informed about admission and condition. (5)	5. Encourage the client to sign a release of information form; contact significant others to gain support for the client's admission to treatment.
5. Cooperate with a physician evaluation and take all medications as prescribed. (6)	6. Refer the client to a physician to examine him/her, educate about substance intoxication and withdrawal, order medications as appropriate, titrate medications, and monitor for effectiveness and side effects.
6. Report as to medication compliance, effectiveness, and side effects. (7, 8)	7. Direct the medical staff to carry out the orders of the physician and to administer medications as directed.
	8. Monitor the client's medications for compliance, effectiveness, and side effects.
7. Provide information for a biopsychosocial assessment of the extent of addiction/dependence. (9)	9. Complete a biopsychosocial assessment to determine the extent of the client's addiction and the need for treatment.
8. Agree to stay with a staff member or treatment buddy during severe intoxication/withdrawal. (10)	10. Assign a staff member to remain with the client until he/she is through intoxication and withdrawal.
9. Report any change in symptoms of intoxication/withdrawal to the medical staff. (3, 11)	3. Administer to the client psychological instruments designed to objectively assess substance intoxication/withdrawal (e.g., Clinical Institute of Withdrawal Scale, Narcotic Withdrawal Scale); give the client feedback regarding the results of the assessment.

	11. Teach the client what signs and symptoms he/she may experience during substance intoxication and/or withdrawal (or assign "Coping with Post-Acute Withdrawal [PAW]" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz); encourage him/her to report any significant change in symptoms to the medical staff.
10. Blood work shows no presence of mood-altering substances. (12)	12. Monitor the client's status via blood tests, and report findings in the clinical chart.
11. Vital signs stabilized within normal parameters. (13)	13. Monitor the client's vital signs and document the findings in his/her chart.
12. Demonstrate that cognitive, behavioral, and emotional functioning have returned to preintoxication status. (3, 14)	3. Administer to the client psychological instruments designed to objectively assess substance intoxication/withdrawal (e.g., Clinical Institute of Withdrawal Scale, Narcotic Withdrawal Scale); give the client feedback regarding the results of the assessment.
	14. Evaluate the client's cognitive, behavioral, and emotional status as detoxification progresses, reporting the results on his/her chart.
13. Share the feelings that surround admission for substance intoxication/withdrawal. (9, 15, 16, 17)	9. Complete a biopsychosocial assessment to determine the extent of the client's addiction and the need for treatment.
	15. Probe the client's feelings that surround his/her substance intoxication and admission for addiction treatment.
	16. Teach the client that substance withdrawal means substance dependence; help him/her to make plans for treatment and recovery.

	17. Share the results of a chemical dependence assessment, and discuss options for the treatment of addiction/dependence.
14. Sign a contract with the staff that the client will inform the staff if he/she has thoughts of causing harm to self or others. (18, 19)	18. Assess danger to the client or others; encourage him/her to report any thoughts of causing harm to himself/herself or others.
	19. Help the client to reduce environmental stimulation to a level that will not exacerbate symptoms and not increase agitation.
15. Learn and cooperate with the rules of the treatment program. (20)	20. Teach the client the rules of the treatment program; encourage him/her to follow the rules while in treatment.
16. In a family session, discuss the connection between withdrawal symptoms and addiction. (21)	21. In a family session, discuss withdrawal symptoms and their connection with addiction.
17. Read letters of support from family members. (22)	22. Encourage the family members to write letters of support to the client; have him/her read the letters.
18. Complete a re-administration of objective tests of substance intoxication/withdrawal as a means of assessing treatment outcome. (23)	23. Assess the outcome of treatment by re-administering to the client objective tests of substance intoxication/withdrawal; evaluate the results and provide feedback to the client.
19. Complete a survey to assess the degree of client's satisfaction with treatment. (24)	24. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	303.00	Alcohol Intoxication
	292.89	Amphetamine Intoxication
	305.90	Caffeine Intoxication
	292.89	Cannabis Intoxication
	292.89	Cocaine Intoxication
	292.89	Hallucinogen Intoxication
	292.89	Opioid Intoxication
	292.89	Phencyclidine Intoxication
	292.89	Sedative, Hypnotic, or Anxiolytic Intoxication
	291.81	Alcohol Withdrawal
	292.0	Amphetamine Withdrawal
	292.0	Cocaine Withdrawal
	292.0	Opioid Withdrawal
	292.0	Sedative, Hypnotic, or Anxiolytic Withdrawal
	292.81	Other (or unknown) Substance Intoxication
	292.0	Other (or unknown) Substance Withdrawal
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SUICIDAL IDEATION

BEHAVIORAL DEFINITIONS

1. Reports recurrent thoughts of and preoccupation with death.
2. Reports recurrent or ongoing suicidal ideation without any plans.
3. Expresses ongoing suicidal ideation with a specific plan.
4. Presents with chemical dependency or addiction that exacerbates depression, hopelessness, and suicidal ideation.
5. Reports losses due to addiction (e.g., financial, familial, vocational), which leave the client feeling suicidal and hopeless about his/her life.
6. Verbalizes belief that everyone would be better of if he/she was dead.
7. Has a history of suicide attempts.
8. Verbalizes profound feelings of helplessness, hopelessness, and worthlessness.
9. Reports the loss of a significant other to suicide or death, and has recurrent fantasies about joining the other person.
10. Expresses a bleak, hopeless attitude regarding life, coupled with recent losses that support this belief (e.g., divorce, death of spouse, illness, loss of job).

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LONG-TERM GOALS

1. Resolve preoccupation with death, find new hope, and enter a program of recovery, free of addiction and suicidal ideation.
2. Terminate all suicidal urges, express hope for the future, and remain abstinent from all mood-altering substances.
3. Placement at the level of care necessary to protect the client from his/her suicidal impulses.
4. Understand the relationship between suicidal ideation and addiction.
5. Develop a sense of worth to other addicts and family members.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Verbalize specific suicidal thoughts, feelings, plans, and actions. (1, 2)	1. Assess the dangerousness of the suicidal ideation by asking the client to share suicidal feelings, thoughts, plans, and behaviors. 2. Explore the client's reasons for suicidal ideation: feelings of helplessness, hopelessness, and worthlessness.
2. Complete psychological testing or objective questionnaires for assessing suicidal ideation. (3)	3. Administer to the client psychological instruments designed to objectively assess suicidal ideation (e.g., Beck Depression Inventory II [BDI-II], Beck Scale for Suicide Ideation [BSS]); give the client feedback regarding the results of the assessment.
3. Sign a no-self-harm contract and agree to contact a staff member if feeling suicidal. (4)	4. Have the client sign a no-self-harm contract that states that he/she will do nothing to harm himself/herself while in treatment, and that he/she

	will contact a staff member if feeling suicidal.
4. Agree to the level of care that is necessary to protect self from suicidal impulses. (5, 6)	5. Discuss the levels of care that are available (e.g., locked room, staying close by a staff member, transfer to a more intensive level of care); admit the client to the level of care that will be necessary to protect him/her from suicidal impulses.
	6. Assign a staff member to stay with the client until his/her suicidal threat is resolved.
5. Participate in an evidence-based therapy. (7)	7. Assess the client for an identifiable clinical syndrome or personality disorder (e.g., depression, borderline personality, bipolar disorder); refer him/her to the appropriate evidence-based psychotherapeutic intervention (see relevant chapters in this *Planner*).
6. Verbalize an understanding of how suicide risk is magnified by addiction. (8)	8. Assist the client in understanding how feelings of shame, loss, and hopelessness are exacerbated by addictive behavior.
7. Identify the losses sustained because of addiction. (9)	9. Review the losses (e.g., marital, familial, social, legal, financial, health, occupational) that have resulted from addictive behavior and have led to suicidal hopelessness.
8. Verbalize feeling a sense of importance to family members and other addicts in recovery. (10, 11)	10. Help the client to see the meaning behind the 12-step recovery program's saying, "What we cannot do alone, we can do together"; help the client to see that other addicts need his/her support in recovery.
	11. Review the client's role of importance to family and friends (or assign "Why Do I Matter and Who Cares?" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz);

confront minimization or disconnecting.

9. Meet with a physician for an assessment for the need for psychotropic medication. (12)

12. Refer the client to a physician to examine him/her, discuss suicidal ideation and addiction, order medications as indicated, titrate medications, and monitor for side effects.

10. Take all medications as directed. (13, 14)

13. Direct the staff to administer the client's prescribed medications.

14. Monitor the client's medication for compliance, effectiveness, and side effects.

11. Keep a record of self-defeating thoughts, and replace each dysfunctional thought with positive, self-enhancing self-talk. (15, 16)

15. Assist the client in developing an awareness of his/her cognitive messages that reinforce hopelessness and helplessness; assign him/her to keep a daily record of self-defeating thoughts (e.g., thoughts of hopelessness, helplessness, worthlessness, catastrophizing, negatively predicting the future).

16. Challenge each of the client's self-defeating thoughts for accuracy; replace each dysfunctional thought with a thought that is positive and self-enhancing (or assign "Negative Thoughts Trigger Negative Feelings" or "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

12. List the reasons for new hope for the future. (17, 18, 19)

17. Provide the client with reasons for new hope in recovery (e.g., being in treatment offers hope, working with trained professionals who can act as an advocate, other addicts can encourage him/her, staff members are supportive).

18. Encourage the client regarding the excellent chances for recovery

	from addiction and depression if he/she works the 12-step program.
	19. Assign the client to read "the promises" on pages 83 and 84 of the Alcoholics Anonymous (AA) *Big Book;* encourage him/her to verbalize hope for the future.
13. List reasons for wanting to live. (11, 20, 21)	11. Review the client's role of importance to family and friends (or assign "Why Do I Matter and Who Cares?" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz); confront minimization or disconnecting.
	20. Help the client to list reasons to live (e.g., positive people, places, things that are a part of his/her life).
	21. Assign the client to write a list of the positive people, places, and things in his/her life.
14. Verbalize new hope for resolving interpersonal conflicts because of being in addiction treatment. (22, 23)	22. Help the client to see the new hope that addiction treatment brings to the resolution of interpersonal conflicts.
	23. Meet with the client and a significant other with whom there is conflict, to begin a process of conflict resolution.
15. Verbalize an understanding of the 12-step *attitude of gratitude*; list five things to be grateful for each day. (24)	24. Teach the client about the 12-step recovery program's concept of the *attitude of gratitude*; assign him/her to list five things for which he/she is grateful for each day.
16. Verbalize coping strategies that will elevate depressed mood. (25)	25. Assist the client in developing coping strategies for suicidal ideation (e.g., more physical exercise, less internal focus, increased social involvement, more expression of feelings).
17. Encourage someone else in recovery at least once a day. (19, 26)	19. Assign the client to read "the promises" on pages 83 and 84 of the Alcoholics Anonymous *Big*

Book; encourage him/her to verbalize hope for the future.

26. Assign the client to encourage someone in treatment each day; record each event and discuss with the therapist.

18. Verbalize an understanding of the 12-step program's concept of a higher power, and how this can be used to recover from suicidal ideation and addictive behavior. (27, 28)

27. Teach the client about the 12-step recovery program's concept of a higher power; encourage the client to ask a higher power for direction each day.

28. Assign the client to read Chapter 11 in *Twelve Steps and Twelve Traditions* (AA); encourage him/her to pray and meditate at least once each day.

19. List three things that each family member can do to assist the client in recovery. (29, 30)

29. In a family session, have the client discuss the connection between suicidal ideation and addiction.

30. Help the client to list three things that each family member can do to assist him/her in recovery; assign the client to share these with the family members and report back to the therapist.

20. Complete a re-administration of objective tests of suicidal ideation as a means of assessing treatment outcome. (31)

31. Assess the outcome of treatment by re-administering to the client objective tests of suicidal ideation; evaluate the results and provide feedback to the client.

21. Complete a survey to assess the degree of satisfaction with treatment. (32)

32. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	296.xx	Major Depressive Disorder
	300.4	Dysthymic Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	309.0	Adjustment Disorder with Depressed Mood
	291.89	Alcohol-Induced Mood Disorder
	292.84	Amphetamine-Induced Mood Disorder
	292.84	Cocaine-Induced Mood Disorder
	292.84	Inhalant-Induced Mood Disorder
	292.84	Opioid-Induced Mood Disorder
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Axis II:	301.83	Borderline Personality Disorder
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TREATMENT RESISTANCE

BEHAVIORAL DEFINITIONS

1. Verbalizes severe denial of addiction in spite of strong evidence of loss of control, withdrawal symptoms, and many negative consequences of addiction.
2. Substitutes a secondary problem as the focus of concern rather than admit that addiction is the primary problem.
3. Demonstrates anger toward family members, court, or employer for giving an ultimatum for treatment.
4. Refuses to cooperate with the staff and remains a constant risk of leaving treatment against medical advice.
5. Is verbally abusive toward others, irritable, restless, and angry.
6. Demonstrates dishonesty to self and others rather than to the facts regarding own addiction.
7. Constantly uses the telephone to make demands of a friend or family member to come and take him/her out of treatment.
8. Refuses to talk to or bond with treatment peers.

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LONG-TERM GOALS

1. Accept the truth about the problems that addiction has caused, and enter a program of recovery.
2. Accept the powerlessness and unmanageability that addiction has brought to life, and actively engage in the treatment process.
3. Learn the facts about addiction, and make a logical decision about the treatment necessary to arrest it.
4. Cooperate with addiction assessments and accept the diagnosis and treatment plan.
5. Resolve anger at others and accept responsibility for the problems caused by addiction and for the need for treatment.
6. Cooperate with medical management for withdrawal, and agree to enter a 12-step program of recovery.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Share the feelings that surround admission to treatment. (1, 2)	1. Probe the reasons why the client is resisting treatment; check for the accuracy of his/her beliefs about addiction. 2. Encourage the client to share the fear, sadness, shame, and anger that he/she feels about coming for treatment.
2. Cooperate with a biopsychosocial assessment and accept the treatment recommendations. (3)	3. Conduct a biopsychosocial assessment, and collect laboratory results and collateral information from friends and relatives; share these results with the client.
3. Complete psychological testing or objective questionnaires for assessing treatment resistance. (4)	4. Administer to the client psychological instruments designed to objectively assess

	treatment resistance (e.g., Correctional Treatment Resistance Scale, Therapeutic Reactance Scale [TRS]); give the client feedback regarding the results of the assessment.
4. Cooperate with a physician's examination. (5)	5. Refer the client to a physician to examine the client and share the results of the client's history and physical, pointing out signs and symptoms of prolonged and excessive addiction.
5. Listen to the results of the assessments, and make a rational, informed choice about the treatment that is needed to arrest addiction. (6, 7, 8)	6. Using the biopsychosocial and medical assessments, help the client to make an informed choice about addiction treatment. 7. Discuss the levels of care that are available (e.g., recovery group meetings, counseling, outpatient treatment, intensive outpatient, day treatment, residential treatment) and help the client to make an informed decision about entering treatment. 8. Teach the client about the treatment process, and encourage him/her to stay in treatment as long as necessary to bring the addiction under control (or assign "How Far Have I Come?" in the *Addiction Treatment Homework Planner*, 4th ed. by Finley and Lenz).
6. Provide data for a Stage of Change assessment. (9)	9. Assess the client's position in the Stage of Change (see *Substance Abuse Treatment and the Stages of Change* by Conners, Donovan, and DiClemente); provide feedback of results.
7. List times when addictive behavior led to negative consequences. (10)	10. Help the client to see the extent of his/her addiction by assisting him/her in listing a number of negative consequences that have resulted from addictive behavior.

8. Concerned family members, friends, employer, and/or coworkers express their concerns about the client's addiction. (11, 12)	11. Ask the client to sign releases of information and to meet with his/her employer, family, friends, and/or coworkers to enlist their support for him/her to remain in treatment. 12. Ask concerned family, friends, employer, and coworkers to write letters, stating specific instances when the client's addiction hurt them, and to share what they are going to do if the client refuses treatment; if possible, have each person read the letters to the client in a group setting.
9. Sign a release of information to the probation, parole, or court services worker so information can be shared concerning treatment. (13)	13. Ask the client to sign a release of information, and contact his/her probation, parole, or court services worker to elicit support for treatment.
10. Discuss the reasons for treatment resistance with treatment peers, and listen to their feedback. (14, 15)	14. In a group setting, encourage the client to share why he/she does not want to remain in treatment; facilitate other clients' confrontation of denial and support for the need for treatment. 15. Encourage the client to discuss with peers and staff his/her plans to leave treatment.
11. Stay with a staff member or treatment buddy until the threat of leaving treatment resolves. (16)	16. Assign a staff member or treatment peer to stay with the client until the risk of leaving treatment is resolved.
12. List lies that were told to hide addiction. (17)	17. Help the client to admit to the lies that he/she told to hide his/her addiction.
13. Develop a written personal recovery plan that includes the treatment that is necessary to maintain abstinence. (18)	18. Help the client to develop a written personal recovery plan detailing the treatment that is necessary to maintain abstinence (or assign "Setting and Pursuing Goals in Recovery" in the *Addiction*

Treatment Homework Planner, 4th ed. by Finley and Lenz).

14. Make a list of things that each family member can do to assist the client in recovery. (19, 20)

15. Complete a re-administration of objective tests of treatment resistance as a means of assessing treatment outcome. (21)

16. Complete a survey to assess the degree of satisfaction with treatment. (22)

19. In a family session, teach the family members the role of denial in treatment resistance and addiction.

20. Help the client to list three things that each family member can do to assist in recovery; facilitate a sharing of these with family members.

21. Assess the outcome of treatment by re-administering to the client objective tests of treatment resistance; evaluate the results and provide feedback to the client.

22. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Axis I:	305.00	Alcohol Abuse
	305.70	Amphetamine Abuse
	305.20	Cannabis Abuse
	305.60	Cocaine Abuse
	305.30	Hallucinogen Abuse
	305.90	Inhalant Abuse
	305.50	Opioid Abuse
	305.40	Sedative, Hypnotic, or Anxiolytic Abuse
	303.90	Alcohol Dependence
	304.40	Amphetamine Dependence
	304.30	Cannabis Dependence
	304.20	Cocaine Dependence
	304.50	Hallucinogen Dependence
	304.60	Inhalant Dependence
	304.00	Opioid Dependence
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
	304.80	Polysubstance Dependence
	305.90	Phencyclidine Abuse
	304.90	Phencyclidine Dependence
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Axis II:	301.7	Antisocial Personality Disorder
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Appendix A

BIBLIOTHERAPY SUGGESTIONS

General

Many references are made throughout the chapters to four therapeutic homework resources especially relevant to counseling with adults and adolescents struggling with addiction and mental health issues. Rather than cite them repeatedly, they are cited here under the General heading:

Finley, J., & Lenz, B. (2009). *Addiction Treatment Homework Planner,* 4th ed. Hoboken, NJ: John Wiley & Sons.

Jongsma, A. (2006). *Adult Psychotherapy Homework Planner,* 2nd ed. Hoboken, NJ: John Wiley & Sons.

Jongsma, A., Peterson, M., & McInnis, W. (2006). *Adolescent Psychotherapy Homework Planner,* 2nd ed. Hoboken, NJ: John Wiley & Sons.

Perkinson, R. (2003). *The Alcoholism & Drug Abuse Patient Workbook.* Thousand Oaks, CA: Sage Publications.

Adult-Child-of-an-Alcoholic (ACOA) Traits

Al-Anon Family Group. (1994). *From Survival to Recovery: Growing Up in an Alcoholic Family.* Virginia Beach, VA: Al-Anon Family Group.

Bowden, J. D., Gravitz, H. L., Wegscheider, C., & Bowden, J. D. (1987). *Recovery: A Guide for Adult Children of Alcoholics.* New York: Fireside.

Kritsberg, W. (1998). *The Adult Children of Alcoholics Syndrome: From Discovery to Recovery.* New York: Bantam Books.

Woititz, J. G. (1990). *Adult Children of Alcoholics.* Palm Coast, FL: Health Communications.

Woititz, J., & Ackerman, R. (2002). *The Complete ACOA Sourcebook: Adult Children of Alcoholics at Home, at Work and in Love.* Palm Coast, FL: HCI.

Anger

Alberti, R., & Emmons, M. (2008). *Your Perfect Right.* San Luis Obispo, CA: Impact.

Bilodeau, L. (1992). *The Anger Workbook.* Minneapolis, MN: Compare Publications.

Deffenbacher, J. L., & McKay, M. (2000). *Overcoming Situational and General Anger: Client Manual (Best Practices for Therapy).* Oakland, CA: New Harbinger Publications.

Gottlieb, M. (1999). *The Angry Self: A Comprehensive Approach to Anger Management.* Redding, CT: Zeig, Tucker & Theisen.

Harbin, T. J. (2000). *Beyond Anger: A Guide for Men: How to Free Yourself from the Grip of Anger and Get More Out of Life.* New York: Marlowe & Co.

Lee, J., & Stott, B. (1995). *Facing the Fire: Experiencing and Expressing Anger Appropriately.* New York: Bantam Doubleday Dell.

Lerner, H. (1997). *The Dance of Anger: A Woman's Guide to Changing the Patterns of Intimate Relationships.* New York: HarperCollins.

McKay, M., & Rogers, P. (2000). *The Anger Control Workbook*. Oakland, CA: New Harbinger Publications.

McKay, M., Rogers, P. D., & McKay, J. (2003). *When Anger Hurts: Quieting the Storm Within.* Oakland, CA: New Harbinger Publications.

Rosellini, G., & Worden, M. (1997). *Of Course You're Angry.* San Francisco: Harper Hazelden.

Rubin, T. I. (1998). *The Angry Book.* New York: Touchstone.

Smedes, L. (2007). *Forgive and Forget: Healing the Hurts We Don't Deserve.* San Francisco: HarperOne.

Weisinger, H. (1985). *Dr. Weisinger's Anger Work-out Book.* New York: Quill.

Williams, R., & Williams, V. (1998). *Anger Kills: Seventeen Strategies for Controlling the Hostility That Can Harm Your Health.* New York: Harper Mass Market Paperbacks.

Antisocial Behavior

Bilodeau, L. (1992). *The Anger Workbook.* Minneapolis, MN: Compare Publications.

Gottlieb, M. (1999). *The Angry Self: A Comprehensive Approach to Anger Management.* Redding, CT: Zeig, Tucker & Theisen.

Sharp, B. (2000). *Changing Criminal Thinking: A Treatment Program.* Lanham, MD: American Correctional Association.

Wolman, B. (1999). *Antisocial Behavior: Personality Disorders from Hostility to Homicide.* Amherst, NY: Prometheus Books.

Anxiety

Antony, M., Craske, M., & Barlow, D. (2006). *Mastering Your Fears and Phobias, Workbook,* 2nd Edition. New York: Oxford University Press.

Antony, M., & Swinson, R. (2008). *The Shyness & Social Anxiety Workbook: Proven Techniques for Overcoming Your Fears.* Oakland, CA: New Harbinger Publications.

Barlow, D., & Craske, M. (2007). *Mastery of Your Anxiety and Panic, Workbook.* 4th Edition, New York: Oxford University Press.

Bradshaw, J. (2005). *Healing the Shame That Binds You.* Deerfield Beach, FL: Health Communications.

Burns, D. (1985). *Intimate Connections: The New Clinically Tested Program for Overcoming Loneliness.* New York: William Morrow.

Dayhoff, S. (2000). *Diagonally Parked in a Parallel Universe: Working Through Social Anxiety.* Placitas, NM: Effectiveness-Plus Publications.

Goldman, C., & Babior, S. (1996). *Overcoming Panic, Anxiety, & Phobias: New Strategies to Free Yourself from Worry and Fear.* Duluth, MN: Whole Person Associates.

Hayes, S. C. (2005). *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications.

Helmstetter, S. (1990). *What to Say When You Talk to Yourself.* New York: Pocket.

Hofmann, S., & Dibartolo, P. (Eds.). (2000). *From Social Anxiety to Social Phobia: Multiple Perspectives.* Needham Heights, MA: Allyn & Bacon.

Leahy, R. L. (2006). *The Worry Cure: Seven Steps to Stop Worry from Stopping You*. New York: Three Rivers Press.

Perkinson, R. (2003). *The Alcoholism & Drug Abuse Patient Workbook.* Thousand Oaks, CA: Sage Publications.

Peurifoy, R. (1995). *Anxiety, Phobias, and Panic: A Step-by-Step Program for Regaining Control of Your Life.* New York: Warner Books.

Rapee, R. (1999). *Overcoming Shyness and Social Phobia: A Step-by-Step Guide.* Northvale, NJ: Jason Aronson.

Zimbardo, P. (1990). *Shyness: What It Is and What to Do About It.* Reading, MA: Addison-Wesley.

Attention-Deficit/Hyperactivity Disorder (ADHD) — Adolescent and Adult

Barkley, R. A. (2000). *Taking Charge of ADHD: The Complete, Authoritative Guide for Parents.* New York: Guilford Press.

Hollowell, E. M., & Ratey, J. J. (1995). *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood Through Adulthood.* New York: Simon & Schuster.

Ingersoll, B. (1995). *Distant Drums, Different Drummers: A Guide for Young People with ADHD.* Buffalo, NY: Cape Publishing.

Kelly, K., & Ramundo, P. (2006). *You Mean I'm Not Lazy, Stupid or Crazy?!: A Self-Help Book for Adults with Attention Deficit Disorder.* New York: Scribner.

Murphy, K. R., & Levert, S. (1995). *Out of the Fog: Treatment Options and Coping Strategies for Adult Attention Deficit Disorder.* New York: Hyperion.

Quinn, P. O., & Stern, J. M. (2001). *Putting on the Brakes: Young People's Guide to Understanding Attention Deficit Hyperactive Disorder.* Washington, D.C.: Magination.

Safren, S. A. (2005). *Mastering Your Adult ADHD: A Cognitive-Behavioral Treatment Program—Client Workbook*. New York: Oxford University Press.

Attention-Deficit/Inattentive Disorder (ADD)

Barkley, R. A. (2000). *Taking Charge of ADHD: The Complete, Authoritative Guide for Parents.* New York: Guilford Press.

Hollowell, E. M., & Ratey, J. J. (1995). *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood Through Adulthood.* New York: Simon & Schuster.

Ingersoll, B. (1995). *Distant Drums, Different Drummers: A Guide for Young People with ADHD.* Buffalo, NY: Cape Publishing.

Kelly, K., & Ramundo, P. (2006). *You Mean I'm Not Lazy, Stupid or Crazy?!: A Self-Help Book for Adults with Attention Deficit Disorder.* New York: Fireside.

Murphy, K. R., & Levert, S. (1995). *Out of the Fog: Treatment Options and Coping Strategies for Adult Attention Deficit Disorder.* New York: Hyperion.

Quinn, P. O., & Stern, J. M. (2001). *Putting on the Brakes: Young People's Guide to Understanding Attention Deficit Hyperactive Disorder.* Washington, D.C.: Magination.

Safren, S. A. (2005). *Mastering Your Adult ADHD: A Cognitive-Behavioral Treatment Program—Client Workbook*. New York: Oxford University Press.

Borderline Traits

Finley, J., & Lenz, B. (2009). *Addiction Treatment Homework Planner,* 4th ed. Hoboken, NJ: John Wiley & Sons.

Fruzetti, A. E., & Linehan, M. M. (2003). *The High Conflict Couple: A Dialectical Behavior Therapy Guide to Finding Peace, Intimacy, & Validation.* Oakland, CA: New Harbinger Publications.

Kreisman, J. J., & Straus, H. (1991). *I Hate You—Don't Leave Me: Understanding Borderline Personality Disorder.* New York: Avon.

Kreisman, J. J., & Straus, H. (2006). *Sometimes I Act Crazy: Living with Borderline Personality Disorder.* Hoboken, NJ: John Wiley & Sons.

Marra, T. (2004). *Depressed and Anxious: The Dialectical Behavior Therapy Workbook for Overcoming Depression & Anxiety*. Oakland, CA: New Harbinger Publications.

Mason, P. T., Kreger, R., & Siever, L. J. (1998). *Stop Walking on Eggshells: Coping When Someone You Care About Has Borderline Personality Disorder.* Oakland, CA: New Harbinger Publications.

McKay, M., Wood, J., & Brantley, J. (2007). *Dialectical Behavior Therapy Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotion Regulation, & Distress Tolerance.* Oakland, CA: New Harbinger Publications.

Moskovitz, R. A. (2001). *Lost in the Mirror: An Inside Look at Borderline Personality Disorder.* Dallas, TX: Taylor Publishers.

Reiland, R. (2004). *Get Me Out of Here: My Recovery from Borderline Personality Disorder.* Center City, MN: Hazeldon Foundation.

Santoro, J., & Cohen, R. (2001). *The Angry Heart: Overcoming Borderline and Addictive Disorders: An Interactive Self-Help Guide.* New York: MJF Books.

Spradlin, S. E. (2003). *Don't Let Your Emotions Run Your Life: How Dialectical Behavior Therapy Can Put You in Control*. Oakland, CA: New Harbinger Publications.

Thornton, M. F., Peterson, E. W., & Barley, W. D. (1997). *Eclipses: Behind the Borderline Personality Disorder.* Madison, AL: Monte Sano Publishers.

Childhood Trauma

Allen, J. (1995). *Coping with Trauma: A Guide to Self-Understanding*. American Psychiatric Press.

Barnhill, J. W., Rosen, R. K., & Granet, R. (1999). *Why Am I Still So Afraid: Understanding Post-Traumatic Stress Disorder.* New York: Dell Publication Co.

Bradshaw, J. (2005). *Healing the Shame That Binds You.* Deerfield Beach, FL: Health Communications.

Draper, P. L. (1996). *Haunted Memories: Healing the Pain of Childhood Abuse.* Old Tappan, NJ: Fleming H. Revell Co.

Flannery, R. B., Jr. (1995). *Post-Traumatic Stress Disorder: The Victim's Guide to Healing and Recovery.* New York: Crossroad/Herder & Herder.

Gil, E. (1984). *Outgrowing the Pain: A Book for and About Adults Abused as Children.* New York: Dell Publishing.

Kennerly, H. (2000). *Overcoming Childhood Trauma: A Self-Help Guide Using Cognitive Behavioral Techniques.* New York: New York University Press.

Kushner, H. (2004). *When Bad Things Happen to Good People.* New York: Anchor Books.

Matsakis, A. (1996). *I Can't Get Over It: A Handbook for Trauma Survivors.* Oakland, CA: New Harbinger Publications.

Matsakis, A. (1998). *Trust After Trauma: A Guide to Relationships for Survivors and Those Who Love Them.* Oakland, CA: New Harbinger Publications.

Rothbaum, Barbara (2007). *Reclaiming Your Life from a Traumatic Experience: A Prolonged Exposure Treatment Program, Workbook.* New York: Oxford University Press.

Schiraldi, G. R. (1999). *The Post-Traumatic Stress Disorder Sourcebook: A Guide to Healing, Recovery and Growth.* Lincolnwood, IL: Lowell House.

Smedes, L. (2007). *Forgive and Forget: Healing the Hurts We Don't Deserve.* San Francisco: HarperOne.

Spradlin, S. E. (2003). *Don't Let Your Emotions Run Your Life: How Dialectical Behavior Therapy Can Put You in Control*. Oakland, CA: New Harbinger Publications.

Chronic Pain

Bernstein, D. A., & Borkovec, T. D. (1973). *Progressive Relaxation Training.* Champaign, IL: Research Press.

Burns, D. (1999). *The Feeling Good Handbook.* New York: Plume.

Burns, D. (1999). *Ten Days to Self Esteem!* New York: Collins Living.

Catalano, E. M., & Hardin, K. N. (1996). *The Chronic Pain Control Workbook: A Step-by-Step Guide for Coping With and Overcoming Pain.* Oakland, CA: New Harbinger Publications.

Caudill, M. (2001). *Managing Pain before It Manages You.* New York: Guilford Press.

Duckro, P., Richardson, W., & Marshall, J. (1999). *Taking Control of Your Headaches.* New York: Guilford Press.

Hunter, M. (1996). *Making Peace with Chronic Pain.* New York: Brunner/Mazel.

Lewandowski, M. (2006). *The Chronic Pain Care Workbook: A Self-treatment Approach to Pain Relief Using the Behavioral Assessment of Pain Questionnaire.* Oakland, CA: New Harbinger Publications.

Otis, John. (2007). *Managing Chronic Pain: A Cognitive-Behavioral Treatment Program*. New York: Oxford University Press.

Willhoff, J. (2004). *Living Well with Chronic Pain*. New York: Thornton Publishing.

Conduct Disorder/Delinquency

Alberti, R., & Emmons, M. (2008). *Your Perfect Right.* San Luis Obispo, CA: Impact.

Bernstein, N. (2001). *How to Keep Your Teenager Out of Trouble and What to Do if You Can't.* New York: Workman Publications.

Canter, L., & Canter, P. (1993). *Assertive Discipline for Parents*. New York: Collins Living.

Deffenbacher, J. L., & McKay, M. (2000). *Overcoming Situational and General Anger: Client Manual (Best Practices for Therapy).* Oakland, CA: New Harbinger Publications.

Forehand, R., & Long, N. (1996). *Parenting the Strong-willed Child.* Chicago: Contemporary Books.

Garner, A. (1997). *Conversationally Speaking: Tested New Ways to Increase Your Personal and Social Effectiveness*. Los Angeles: Lowell House.

Greene, R. W. (2005). *The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, "Chronically Inflexible" Children.* New York: HarperCollins.

Hipp, E. (2008). *Fighting Invisible Tigers: A Stress Management Guide for Teens.* Minneapolis, MN: Free Spirit Publishing.

Katherine, A. (2000). *Where to Draw the Line: How to Set Healthy Boundaries Every Day*. New York: Fireside.

Kazdin, A. (2005). *Parent Management Training: Treatment for Oppositional, Aggressive, and Antisocial Behavior in Children and Adolescents.* New York: Oxford University Press.

Kindlon, D., & Thompson, M. (2000). *Raising Cain: Protecting the Emotional Life of Boys.* New York: Ballantine Publishing Group.

Patterson, G. R. (1976). *Living with Children: New Methods for Parents and Teachers*. Champaign, IL: Research Press.

Robin, A., & Foster, S. (2002). *Negotiating Parent/Adolescent Conflict.* New York: Guilford Press.

Shapiro, L. E. (2001). *Teens' Solution Workbook*. Plainview, NY: Childswork/ Childsplay.

Shore, H. (1995). *The Angry Monster*. King of Prussia, PA: Center for Applied Psychology.

Zodkevitch, R. (2006). *The Toughlove® Prescription.* New York: McGraw-Hill.

Dangerousness/Lethality

Jamison, K. P. (2000). *Night Falls Fast: Understanding Suicide.* New York: Vintage Books.

McKay, M., Rogers, P. D., & McKay, J. (2003). *When Anger Hurts: Quieting the Storm Within.* Oakland, CA: New Harbinger Publications.

Sells, S. (2002). *Parenting Your Out-of-Control Teenager: 7 Steps to Re-establish Authority and Reclaim Love.* New York: St. Martin's Press.

Dependent Traits

Alberti, R., & Emmons, M. (2008). *Your Perfect Right.* San Luis Obispo, CA: Impact.

Alcoholics Anonymous. (1974). *Big Book.* New York: Alcoholics Anonymous General Services Office.

Beattie, M. (2001). *Codependent No More: Beyond Codependency.* New York: MJF Books.

Drews, T. R. (1998). *Getting Them Sober: You Can Help!* Baltimore, MD: Recovery Communications.

Engle, B. (2003). *The Emotionally Abusive Relationship: How to Stop Being Abused and How to Stop Abusing.* Hoboken, NJ: John Wiley & Sons.

Evans, P. (2003). *The Verbally Abusive Relationship.* Holbrook, MA: Bob Adams Inc.

Helmfelt, R., Minirth, F., & Meier, P. (2003). *Love Is a Choice.* Nashville, TN: Nelson.

Norwood, R. (2008). *Women Who Love Too Much.* New York: Pocket.

Pittman, F. (1998). *Grow Up!: How Taking Responsibility Can Make You a Happy Adult.* New York: Golden Books.

Whitfield, C. (1994). *Boundaries and Relationships: Knowing, Protecting, and Enjoying the Self.* Deerfield Beach, FL: Health Communications.

Depression

Addis, M. E., & Martell, C. R. (2004). *Overcoming Depression One Step at a Time: The New Behavioral Activation Approach to Getting Your Life Back*. Oakland, CA: New Harbinger Publications.

Burns, D. (1999). *The Feeling Good Handbook.* New York: Plume.
Burns, D. (1999). *Ten Days to Self Esteem!* New York: Collins Living.
Copeland, M., & McKay, M. (2004). *The Depression Workbook: A Guide for Living with Depression and Manic Depression.* Oakland, CA: New Harbinger Publications.
Cronkite, K. (1995). *On the Edge of Darkness: Conversations about Conquering Depression.* New York: Delta.
Gilson, M., & Freeman, A. (2004). *Overcoming Depression: A Cognitive Therapy Approach for Taming the Depression BEAST Client Workbook.* New York: Oxford University Press.
Golant, M., & Golant, S. K. (2007). *What to Do When Someone You Love Is Depressed: A Practical, Compassionate and Helpful Guide.* New York: Holt.
Hayes, S. C. (2005). *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications.
Lewinsohn, P. (1992). *Control Your Depression*. New York: Fireside.
Miklowitz, D. J. (2002) *Bipolar Disorder Survival Guide: What You and Your Family Need to Know*. New York: Guilford Press.
O'Connor, R. (1999). *Undoing Depression: What Therapy Doesn't Teach You and Medication Can't Give You.* New York: Berkley Publishing Group.
Pettit, J. W., Joiner, T. E., & Rehm, L. P. (2005). *The Interpersonal Solution to Depression: A Workbook for Changing How You Feel by Changing How You Relate*. Oakland, CA: New Harbinger Publications.
Rosen, L. E., & Amador, X. F. (1997). *When Someone You Love Is Depressed: How to Help Your Loved One Without Losing Yourself.* New York: Fireside.
Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2001). *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse*. New York: Guilford Press.
Thorn, J., & Rothstein, L. (1993). *You Are Not Alone: Words of Experience and Hope for the Journey Through Depression.* New York: Harper Perennial.
Yapko, M. (1998). *Breaking the Patterns of Depression*. New York: Main Street Books.
Weissman, M. M. (2005). *Mastering Depression through Interpersonal Psychotherapy: Patient Workbook*. New York: Oxford University Press.

Eating Disorders

Agras, Stuart W. (2007). *Overcoming Your Eating Disorder: A Cognitive-Behavioral Therapy Approach for Bulimia Nervosa and Binge Eating Disorder. Guided Self Help Workbook.* New York: Oxford University Press.
Claude-Pierre, P. (1999). *The Secret Language of Eating Disorders: The Revolutionary New Approach.* New York: Vintage Books.
Costin, C. (2006). *The Eating Disorder Source Book: A Comprehensive Guide to the Causes, Treatments, and Prevention of Eating Disorders.* New York: McGraw-Hill.
Fairburn, C. G. (1995). *Overcoming Binge Eating*. New York: Guilford Press.
Goodman, L. (1995). *Is Your Child Dying to Be Thin?: A Workbook for Parents and Family Member on Eating Disorders.* Pittsburgh, PA: Dorrance Publishing.

Hettner, M., & Eitert, G. (2004). *The Anorexic Workbook.* Oakland, CA: New Harbinger Publications.

Jantz, G. L. (2000). *Hope, Help, and Healing for Eating Disorders: A New Approach to Treating Anorexia, Bulimia, and Overeating.* Wheaton, IL: Shaw Books.

McCabe, R., McFarlane, T., & Olmsted, M. (2004). *Overcoming Bulimia Workbook.* Oakland, CA: New Harbinger Publications.

Sacker, I. M., & Zimmer, M.A. (1995). *Dying to Be Thin: Understanding & Defeating Anorexia & Bulimia.* New York: Warner Books.

Siegel, M. (1997). *Surviving an Eating Disorder: Strategies for Family and Friends.* New York: HarperCollins.

Family Conflicts

Beattie, M. (2001). *Codependent No More: Beyond Codependency.* New York: MJF Books.

Covey, S. R., & Covey, S. M. (1999). *The 7 Habits of Highly Effective Families: Building a Beautiful Family Culture in a Turbulent World.* New York: Simon & Schuster.

Page, S., & Page, S. (1998). *How One of You Can Bring the Two of You Together: Breakthrough Strategies to Resolve Conflicts and Reignite Your Love.* New York: Bantam Doubleday Dell.

Robinson, J. (1997). *Communication Miracles for Couples: Easy and Effective Tools to Create More Love and Less Conflict.* New York: Conari Publishing.

Sherven, J., & Sniechowski, J. (1997). *The New Intimacy: Discovering the Magic at the Heart of Your Differences.* Palm Coast, FL: Health Communications.

Weinhold, B., & Weinhold, J. (2008). *Breaking Free of the Co-Dependency Trap.* Novato, CA: New World Library.

Gambling

Berman, L., & Siegel, M. (2008). *Behind the 8-Ball: A Guide for Families of Gamblers.* iUniverse.com.

Chamberlain, L., & McCowan, W. G. (2000). *Best Possible Odds: Contemporary Treatment Strategies for Gambling Disorders.* New York: John Wiley & Sons.

Eadington, W. R., & Cornelius, J. A. (2000). *The Downside: Problem and Pathological Gambling.* Las Vegas, NV: University of Nevada Press.

Federman, E. J., Drebing, C. E., & Krebs, C. (2000). *Don't Leave It to Chance: A Guide for Families of Problem Gamblers.* Oakland, CA: New Harbinger Publications.

Herscovitch, A. (1999). *Alcoholism and Pathological Gambling: Similarities and Differences.* Holmes Beach, FL: Learning Publications.

May, G. G. (2007). *Addiction and Grace.* San Francisco: HarperOne.

Perkinson, R. (2003). *The Gambling Addiction Patient Workbook.* Thousand Oaks, CA: Sage.

Grief/Loss Unresolved

Caplan, S., & Lang, G. (1995). *Grief's Courageous Journey: A Workbook.* Oakland, CA: New Harbinger Publications.

Childs-Gowell, E. (1992). *Good Grief Rituals: Tools for Healing: A Healing Companion.* Barrytown, NY: Station Hill Press.

Colgrove, M., Bloomfield, H., & McWilliams, P. (1993). *How to Survive the Loss of a Love.* Los Angeles: Prelude Press.

Harris-Lord, J. (2006). *No Time for Goodbyes: Coping with Sorrow, Anger, and Injustice After a Tragic Death.* Burnsville, NC: Compassion Books.

James, J., & Friedman, R. (1998). *The Grief Recovery Handbook: The Action Program for Moving Beyond Death, Divorce, and Other Losses.* New York: HarperCollins.

Kushner, H. (2004). *When Bad Things Happen to Good People.* New York: Anchor.

Obershaw, R. (2004). *Cry Until You Laugh: Comforting Guidance for Coping with Grief.* Edina, MN: Beavers Pond Press.

Smedes, L. (2007). *Forgive and Forget: Healing the Hurts We Don't Deserve.* San Francisco: HarperOne.

Westberg, G. (2004). *Good Grief: A Constructive Approach to the Problem of Loss.* Minneapolis, MN: Fortress Press.

Zonnebelt-Smeenge, S., & DeVries, R. (1998). *Getting to the Other Side of Grief: Overcoming the Loss of a Spouse.* Grand Rapids, MI: Baker.

Zonnebelt-Smeenge, S., & DeVries, R. (2006). *Traveling through Grief: Learning to Live Again after the Death of a Loved One.* Grand Rapids, MI: Baker.

Impulsivity

Garber, S., Freedman Spizman, R., & Garber, M. (1995). *Is Your Child Hyperactive? Inattentive? Impulsive? Distractable?: Helping the ADD/Hyperactive Child.* New York: Villard Books.

Hallowell, E., & Ratney, J. (2005). *Delivered from Distraction: Getting the Most out of Life with Attention Deficit Disorder.* New York: Ballantine Books.

Kelly, K., & Ramundo, P. (2006). *You Mean I'm Not Lazy, Stupid or Crazy?!: A Self-Help Book for Adults with Attention Deficit Disorder.* New York: Fireside.

Melody, P., & Miller, A. (1992). *Facing Love Addiction: Giving Yourself the Power to Change the Way You Love & the Love Connection to Codependence.* San Francisco: Harper.

Shapiro, L. (1993). *Sometimes I Drive My Mom Crazy, but I Know She's Crazy About Me: A Self-Esteem Book for Overactive and Impulsive Children.* Woodbury, NY: Childswork/Childsplay.

Legal Problems

Alson, S., & Burnett, G. (2003). *Peace in Everyday Relationships: Resolving Conflicts in Your Personal and Work Life*. Alemeda, CA: Hunter House.

Kheel, T. (1999). *The Keys to Conflict Resolution: Proven Methods of Settling Disputes Voluntarily.* New York: Four Walls Eight Windows.

Mnookin, R., Peppet, S., & Tulumello, A. (2004). *Beyond Winning: Negotiating to Create Value in Deals and Disputes.* Cambridge, MA: Belknap Press.

Seidenberg, R., & Dawes, W. (1997). *The Father's Emergency Guide to Divorce-Custody Battle.* Takoma Park, MD: JES Books.

Smith, G., & Abrahms, S. (2007). *What Every Woman Should Know About Divorce and Custody: Judges, Lawyers, and Therapists Share Winning Strategies on How to Keep the Kids, the Cash and the Family.* New York: Perigee.

Stewart, J. (2000). *The Child Custody Book: How to Protect Your Children and Win Your Case.* Atascadero, CA: Impact Publishers.

Strohm, R. (Ed.). (1997). *Solving Your Financial Problems: Getting Out of Debt, Repairing Your Credit and Dealing with Bankruptcy* (Layman's Law Guide). Broomall, PA: Chelsea House Publishing.

Living Environment Deficiency

Alberti, R., & Emmons, M. (2008). *Your Perfect Right.* San Luis Obispo, CA: Impact.

Engle, B. (2003). *The Emotionally Abusive Relationship: How to Stop Being Abused and How to Stop Abusing.* Hoboken, NJ: John Wiley & Sons.

Forward, S., & Frazier, D. (1998). *Emotional Blackmail.* New York: HarperCollins.

Kaplan, L. (1997). *Coping with Peer Pressure.* Center City, MN: Hazelden.

Kritsberg, W. (1998). *The Adult Children of Alcoholics Syndrome: From Discovery to Recovery.* New York: Bantam Books.

Sachs, S. (1997). *Street Gang Awareness: A Resource Guide for Parents and Professionals.* Minneapolis, MN: Fairview Press.

Woititz, J., & Ackerman, R. (2002). *The Complete ACOA Sourcebook: Adult Children of Alcoholics at Home, at Work and in Love.* Palm Coast, FL: HCI.

Mania/Hypomania

Basco, M. R. (2005). *The Bipolar Workbook: Tools for Controlling Your Mood Swings*. New York: Guilford Press.

Bradley, L. (2004). *Manic Depression: How to Live While Loving a Manic Depressive.* Houston, TX: Emerald Ink Publications.

Copeland, M., & McKay, M. (2004). *The Depression Workbook: A Guide for Living with Depression and Manic Depression.* Oakland, CA: New Harbinger Publications.

Granet, R., & Ferber, E. (1999). *Why Am I Up, Why Am I Down?: Understanding Bipolar Disorder.* New York: Dell.

Miklowitz, D. J. (2002). *The Bipolar Disorder Survival Guide: What You and Your Family Need to Know*. New York: Guilford Press.

Mondimore, F. (2006). *Bipolar Disorder: A Guide for Patients and Families.* Baltimore: Johns Hopkins University Press.

Olson, B., & Olson, M. (1999). *Win the Battle: The 3-Step Lifesaving Formula to Conquer Depression and Bipolar Disorder.* Worchester, MA: Chandler House Press.

Papolos, D., & Papolos, J. (2007). *The Bipolar Child: The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder.* New York: Broadway Books.

Waltz, M. (2000). *Bipolar Disorders: A Guide to Helping Children and Adolescents.* Sebastopol, CA: O'Reilly & Associates.

Medical Issues

American Medical Association (2004). *American Medical Association Family Medical Guide.* Hoboken, NJ: John Wiley & Sons.

Cousins, N. (2005). *Anatomy of an Illness as Perceived by the Patient.* New York: W. W. Norton & Company.

Dollemore, D., & Feinstein, A. (Eds.). (1996). *Symptoms: Their Causes & Cures: How to Understand and Treat 265 Health Concerns.* New York: Bantam Books.

Editors of The Johns Hopkins Medical Guide to Health After 50. (2006). *The Johns Hopkins Medical Guide to Health After 50.* New York: Black Dog and Leventhal Publishers.

Griffith, W., Moore, S., & Yoder, K. (2006). *Complete Guide to Symptoms, Illnesses & Surgery.* New York: Perigee.

McPhee, S., Papadakis, M., & Tierney, L. (2008). *Current Medical Diagnosis and Treatment.* New York: McGraw-Hill Medical.

Narcissistic Traits

Behary, W. (2008). *Disarming the Narcissist: Surviving & Thriving with the Self-Absorbed.* Oakland, CA: New Harbinger Publications.

Brown, N. (1998). *The Destructive Narcissistic Pattern.* Westport, CT: Praeger Publications.

Brown, N. (2006). *Coping with Infuriating, Mean, Critical People: The Destructive Narcissistic Pattern.* Westport, CT: Praeger Publications.

Donaldson-Pressman, S., & Pressman, R. (1997). *The Narcissistic Family: Diagnosis and Treatment.* San Francisco: Jossey-Bass.

Forrest, G. (1994). *Alcoholism, Narcissism and Psychopathology.* Leonia, NJ: Jason Aronson.

Golomb, E. (1995). *Trapped in the Mirror: Adult Children of Narcissists in Their Struggle for Self.* New York: HarperCollins.

Lowen, A. (2004). *Narcissism: Denial of the True Self.* Greenwich, CT: Touchstone.

Nicotine Abuse/Dependence

Ashelman, M. W. (2000). *Stop Smoking Naturally.* New York: NTC/Contemporary Publishing.

Baer, A. (1998). *Quit Smoking for Good: A Supportive Program for Permanent Smoking Cessation.* Freedom, CA: Crossing Press.

Brizer, D. (2003). *Quitting Smoking for Dummies.* Hoboken NJ: John Wiley & Sons.

Fisher, E. B., & Koop, C. E. (1998). *American Lung Association 7 Steps to a Smoke Free Life.* New York: John Wiley & Sons.

Rogers, J. (1995). *You Can Stop Smoking.* New York: Pocket Books.

Wetherall, R. (2007). *Quit: Read This Book and Stop Smoking.* Philadelphia, PA: Running Press Miniature Editions.

Occupational Problems

Finley, J., & Lenz, B. (2009). *Addiction Treatment Homework Planner,* 4th ed. Hoboken, NJ: John Wiley & Sons.

Gill, L. (1999). *How to Work with Just About Anyone: A 3-Step Solution for Getting Difficult People to Change.* New York: Fireside.

Hirsh, S., & Kise, J. (1996). *Work It Out: Clues for Solving People Problems at Work.* Palo Alto, CA: Davies-Black Publishing.

Johnson, S. (1998). *Who Moved My Cheese?: An Amazing Way to Deal with Change in Your Work and in Your Life.* New York: Putnam Publishing Group.

Lloyd, K. (1999). *Jerks at Work: How to Deal with People Problems and Problem People.* Franklin Lakes, NJ: Career Press.

Scanlon, W. (1991). *Alcoholism and Drug Abuse in the Workplace.* Westport, CT: Praeger Publications.

Sharpe, D., & Johnson, E. (2007). *Managing Conflict with Your Boss.* San Francisco: Pfeiffer.

Opioid Dependence

Catalono, E. M., & Hardin, K. N. (1996). *The Chronic Pain Control Workbook: A Step-by-Step Guide for Coping with and Overcoming Pain.* Oakland, CA: New Harbinger Press.

Denning, P., Little, J., & Glickman, A. (2003). *Over the Influence: The Harm Reduction Guide for Managing Drugs and Alcohol*. New York: Guilford Press.

Faber, W. (2007). *Pain Pain Go Away: Free Yourself from Chronic Pain.* Charleston, SC: BookSurge.

Hiesiger, E. (2003). *Your Pain Is Real: Free Yourself from Chronic Pain with Breakthrough Medical Treatments.* New York: Collins Living.

Inaba, D. S., & Cohen, W. E. (2007). *Uppers Downers, All Arounders.* Ashland, OR: CNS Publications.

Jamison, R. N. (1996). *Learning to Master Your Chronic Pain.* Sarasota, FL: Professional Resource Press.

Leith, L. (1998). *Exercising Your Way to Better Mental Health.* Morgantown, WV: Fitness Information Technology.

Marlatt, G. A. (2002). *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*. New York: Guilford Press.

Narcotics Anonymous World Service. (1988). *Narcotics Anonymous.* Los Angeles: Narcotics Anonymous World Service.

Oppositional Defiant Disorder

Alberti, R., & Emmons, M. (2008). *Your Perfect Right.* San Luis Obispo, CA: Impact.

Forehand, R., & Long, N. (1996). *Parenting the Strong-Willed Child.* Chicago: Contemporary Books.

Greene, R. W. (2005). *The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, "Chronically Inflexible" Children.* New York: HarperCollins.

Hipp, E. (2008). *Fighting Invisible Tigers: A Stress Management Guide for Teens.* Minneapolis, MN: Free Spirit Publishing.

Kazdin, A. (2008). *The Kazdin Method for Parenting the Defiant Child: With No Pills, No Therapy, No Contest of Wills.* New York: Houghton Mifflin.

Kazdin, A. (2005). *Parent Management Training: Treatment for Oppositional, Aggressive, and Antisocial Behavior in Children and Adolescents.* New York: Oxford University Press.

Kindlon, D., & Thompson, M. (2000). *Raising Cain: Protecting the Emotional Life of Boys.* New York: Ballantine Publishing Group.

Patterson, G. R. (1977). *Living with Children: New Methods for Parents and Teachers*. Champaign, IL: Research Press.

Riley, D. (1997). *The Defiant Child: A Parents Guide to Oppositional Defiant Disorder.* Dallas, TX: Taylor Publishing Company.

Parent-Child Relational Problem

Adams, J. (2004). *When Our Grown Kids Disappoint Us: Letting Go of Their Problems, Loving Them Anyway, and Getting on with Our Lives.* New York: Free Press.

Campbell, R. (2007). *Help Your Twentysomething Get a Life… And Get It Now: A Guide for Parents.* Nashville, TN: Thomas Nelson.

Forehand, R., & Long, N. (1996). *Parenting the Strong-willed Child.* Chicago: Contemporary Books.

Kazdin, A. (2008). *The Kazdin Method for Parenting the Defiant Child: With No Pills, No Therapy, No Contest of Wills.* New York: Houghton Mifflin.

Kazdin, A. (2005). *Parent Management Training: Treatment for Oppositional, Aggressive, and Antisocial Behavior in Children and Adolescents.* New York: Oxford University Press.

Kline, F., & Fay, J. (2006). *Parenting with Love and Logic.* Colorado Springs, CO: Pinon Press.

Patterson, G. R. (1977). *Living with Children: New Methods for Parents and Teachers*. Champaign, IL: Research Press.

Steinberg, L., & Levine, A. (1997). *You and Your Adolescent: A Parent's Guide for Ages 10 to 20.* New York: HarperCollins.

Woititz, J., & Ackerman, R. (2002). *The Complete ACOA Sourcebook: Adult Children of Alcoholics at Home, at Work and in Love.* Palm Coast, FL: HCI.

Partner Relational Conflicts

Asker, S. (1999). *Plan B: How to Get Unstuck from Work, Family, and Relationship Problems.* New York: Perigee.

Beck, A. (1989). *Love Is Never Enough: How Couples Can Overcome Misunderstanding, Resolve Conflicts, and Solve Relationship Problems Through Cognitive Therapy.* New York: HarperCollins.

Bernstein, J., & Magee, S. (2007). *Why Can't You Read My Mind? Overcoming the 9 Toxic Thought Patterns that Get in the Way of a Loving Relationship.* Cambridge, MA: Da Capo Press.

Christensen, A., & Jacobson, N. S. (2000). *Reconcilable Differences*. New York: Guilford Press.

Crenshaw, R. (1981). *Expressing Your Feelings: The Key to an Intimate Relationship.* New York: Irvington Publications.

Finley, J., & Lenz, B. (2009). *Addiction Treatment Homework Planner,* 4th ed. Hoboken, NJ: John Wiley & Sons.

Gottman, J., & Silver, N. (2000). *The Seven Principles for Making Marriage Work.* New York: Three Rivers Press.

Hendrix, H. (2007). *Getting the Love You Want: A Guide for Couples.* New York: Holt.

Page, S. (1998). *How One of You Can Bring the Two of You Together: Breakthrough Strategies to Resolve Your Conflicts and Reignite Your Love.* New York: Broadway.

Robinson, J. (1997). *Communication Miracles for Couples: Easy and Effective Tools to Create More Love and Less Conflict.* Berkeley, CA: Conari Press.

Stern, S. (1999). *He Just Doesn't Get It: Simple Solutions to the Most Common Relationship Problems.* New York: Pocket Books.

Synder, D., Baucom, D., & Gordon, K. (2007). *Getting Past the Affair: A Program to Help You Cope, Heal, and Move On—Together or Apart.* New York: Guilford Press.

Peer Group Negativity

Alberti, R., & Emmons, M. (2008). *Your Perfect Right.* San Luis Obispo, CA:

Kaplan, L. (1997). *Coping with Peer Pressure.* Center City, MN: Hazelden.

Sachs, S. (1997). *Street Gang Awareness: A Resource Guide for Parents and Professionals.* Minneapolis, MN: Fairview Press.

Scott, S. (1997). *How to Say No and Keep Your Friends: Peer Pressure Reversal for Teens and Preteens.* Amherst, MA: Human Resourse Development Press.

Posttraumatic Stress Disorder (PTSD)

Coffey, R. (1998). *Unspeakable Truths and Happy Endings: Human Cruelty and the New Trauma Therapy.* Towson, MD: Sidran Press.

Flannery, R. B., Jr. (1995). *Post-Traumatic Stress Disorder: The Victim's Guide to Healing and Recovery.* New York: Crossroad/Herder & Herder.

Freyd, J. (1998). *Betrayal Trauma: The Logic of Forgetting Childhood Abuse.* Cambridge, MA: Harvard University Press.

Matsakis, A. (1996). *I Can't Get Over It: A Handbook for Trauma Survivors.* Oakland, CA: New Harbinger Publications.

Matsakis, A. (1998). *Trust After Trauma: A Guide to Relationships for Survivors and Those Who Love Them.* Oakland, CA: New Harbinger Publications.

Rosenbloom, D., Williams, M., & Watkins, B. E. (1999). *Life After Trauma: A Workbook for Healing.* New York: Guilford Press.

Rothbaum, B. (2007). *Reclaiming Your Life from a Traumatic Experience: A Prolonged Exposure Treatment Program, Workbook.* New York: Oxford University Press.

Schiraldi, G. (2000). *The Post-Traumatic Stress Disorder Sourcebook: A Guide to Healing, Recovery, and Growth.* Lincolnwood, IL: Lowell House.

Smyth, L. (2004). *Overcoming Post-Traumatic Stress Disorder—Client Manual.* Oakland, CA: New Harbinger Publications.

Williams, M. B., & Poijula, S. (2002). *The PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms.* Oakland, CA: New Harbinger Publications.

Psychosis

Adamec, C., & Jaffe, D. (1996). *How to Live with a Mentally Ill Person: A Handbook of Day-to-Day Strategies.* Hoboken, NJ: John Wiley & Sons.

Granet, R., & Ferber, E. (1999). *Why Am I Up, Why Am I Down?: Understanding Bipolar Disorder.* New York: Dell.

Mondimore, F. (2006). *Bipolar Disorder: A Guide for Patients and Families.* Baltimore: Johns Hopkins University Press.

Mueser, K., & Gingerich, S. (2006). *The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life.* New York: Guilford Press.

Olson, B., & Olson, M. (1999). *Win the Battle: The 3-Step Lifesaving Formula to Conquer Depression and Bipolar Disorder.* Worchester, MA: Chandler House Press.

Papolos, D., & Papolos, J. (1999). *The Bipolar Child: The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder.* New York: Broadway Books.

Torrey, F. (2001). *Surviving Schizophrenia: A Manual for Families, Consumers and Providers.* New York: Harper Perennial Library.

Waltz, M. (2000). *Bipolar Disorders: A Guide to Helping Children and Adolescents.* Sebastopol, CA: O'Reilly & Associates.

Relapse Proneness

Denning, P., Little, J., & Glickman, A. (2003). *Over the Influence: The Harm Reduction Guide for Managing Drugs and Alcohol*. New York: Guilford Press.

Dorsman, J. (1998). *How to Quit Drugs for Good: A Complete Self-Help Guide.* Roseville, CA: Prima Publishing.

Duwors, G. (2000). *White Knuckles & Wishful Thinking: Learning from the Moment of Relapse in Alcoholism and Other Addictions.* Kirkland, WA: Hogrefe and Huber Publishers.

Gorski, T., & Miller, M. (1986). *Staying Sober: A Guide for Relapse Prevention.* Scottdale, PA: Herald Publishing House.

Gorski, T. (1997). *Passages Through Recovery: An Action Plan for Preventing Relapse.* Center City, MN: Hazelden.

Marlatt, G. A. (2002). Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors. New York: Guilford Press.

Miller, W. R., & Munoz, R. F. (2004). *Controlling Your Drinking: Tools to Make Moderation Work for You*. New York: Guilford Press.

Washton, A., & Boundy, D. (1990). *Willpower's Not Enough: Understanding and Recovering from Addictions of Every Kind.* New York: HarperCollins.

Washton, A., & Zweben, J. (2009). *Cocaine and Methamphetamine Addiction: Treatment, Recovery, and Relapse Prevention.* New York: Norton.

Self-Care Deficits–Primary

American College of Sports Medicine. (2003). *ACSM Fitness Book.* Champaign, IL: Human Kinetics.

American Medical Association (2004). *American Medical Association Family Medical Guide.* Hoboken, NJ: John Wiley & Sons.

Bittman, M. (2003). *How to Cook Everything: The Basics.* Hoboken, NJ: John Wiley & Sons.

Bittman, M. (2008). *How to Cook Everything: 2,000 Simple Recipes for Great Food.* Hoboken, NJ: John Wiley & Sons.

Editors of Good Housekeeping. (2001). *The Good Housekeeping Illustrated Cookbook: America's Bestselling Step-by-Step Cookbook, with More Than 1,400 Recipes.* New York: Hearst Books.

Pinkham, M., & Burg, D. (1994). *Mary Ellen's Complete Home Reference Book.* New York: Three Rivers Press.

Sharkey, B., & Gaskill, S. (2006). *Fitness and Health.* Champaign, IL: Human Kinetics.

Taintor, J., & Taintor, M. (1999). *The Complete Guide to Better Dental Care.* New York: Checkmark Books.

Self-Care Deficits–Secondary

American College of Sports Medicine. (2003). *ACSM Fitness Book.* Champaign, IL: Human Kinetics.

Aslett, D. (1984). *The Cleaning Encyclopedia: Your A to Z Illustrated Guide to Cleaning Like the Pros.* New York: Dell.

Bittman, M. (2003). *How to Cook Everything: The Basics.* Hoboken, NJ: John Wiley & Sons.

Bittman, M. (2008). *How to Cook Everything: 2,000 Simple Recipes for Great Food.* Hoboken, NJ: John Wiley & Sons.

Editors of Good Housekeeping. (2001). *The Good Housekeeping Illustrated Cookbook: America's Bestselling Step-by-Step Cookbook, with More Than 1,400 Recipes.* New York: Hearst Books.

Pinkham, M., & Burg, D. (1994). *Mary Ellen's Complete Home Reference Book.* New York: Three Rivers Press.

Pinkham, M., & Burg, D. (2002). *Mary Ellen's Guide to Good Enough*

Sharkey, B., & Gaskill, S. (2006). *Fitness and Health.* Champaign, IL: Human Kinetics.

Taintor, J., & Taintor, M. (1999). *The Complete Guide to Better Dental Care.* New York: Checkmark Books.

Sexual Promiscuity

Carnes, P. (1992). *Don't Call It Love: Recovery from Sexual Addiction.* New York: Bantam Books.

Carnes, P. J. (2001). *Out of the Shadows: Understanding Sexual Addiction.* Center City, MN: Hazelden.

Knauer, S. (2002). *Recovering from Sexual Abuse, Addictions, and Compulsive Behaviors.* New York: Routledge.

Means, M. (1999). *Living with Your Husband's Secret Wars.* Grand Rapids, MI: Fleming H. Revell Co.

Melody, P., & Miller, A. W. (1992). *Facing Love Addiction: Giving Yourself the Power to Change the Way You Love.* San Francisco: Harper.

Penix-Sbraga, T., & O'Donohue, W. (2004). *The Sex Addiction Workbook: Proven Strategies to Help You Regain Control of Your Life.* Oakland, CA: New Harbinger Publications.

Social Anxiety/Skills Deficit

Antony, M., & Swinson, R. (2008). *The Shyness & Social Anxiety Workbook: Proven, Step-by-Step Techniques for Overcoming Your Fears.* Oakland, CA: New Harbinger Publications.

Bradshaw, J. (2005). *Healing the Shame That Binds You.* Deerfield Beach, FL: Health Communications.

Burns, D. (1985). *Intimate Connections: The New Clinically Tested Program for Overcoming Loneliness.* New York: William Morrow.
Burns, D. (1999). *The Feeling Good Handbook.* New York: Plume.
Burns, D. (1999). *Ten Days to Self Esteem!* New York: Collins Living.
Dayhoff, S. (2000). *Diagonally Parked in a Parallel Universe: Working Through Social Anxiety.* Placitas, NM: Effectiveness-Plus Publications.
Dyer, W. (1978). *Pulling Your Own Strings.* New York: Thomas Crowell.
Fossum, M. A., & Mason, M. J. (1986). *Facing Shame: Families in Recovery.* New York: W. W. Norton.
Harris, A., & Harris, T. (1969). *I'm OK, You're OK.* New York: Harper & Row.
Helmstetter, S. (1990). *What to Say When You Talk to Yourself.* New York: Pocket.
Hilliard, E. (2005). *Living Fully with Shyness and Social Anxiety: A Comprehensive Guide to Gaining Social Confidence.* Cambridge, MA: Da Capo Press.
Rapee, R. (1999). *Overcoming Shyness and Social Phobia: A Step-by-Step Guide.* Northvale, NJ: Jason Aronson.

Spiritual Confusion

Carter, L. (1997). *The Choosing to Forgive Workbook.* Nashville, TN: Thomas Nelson.
Foster, R. (1988). *Celebration of Discipline: The Path to Spiritual Growth.* San Francisco: Harper & Row.
Graham, B. (2000). *Peace with God: The Secret of Happiness.* Nashville, TN: Thomas Nelson.
May, G. (2007). *Addiction and Grace: Love and Spirituality in the Healing of Addictions.* San Francisco: HarperOne.
Parachin, J. (1999). *Engaged Spirituality: Ten Lives of Contemplation and Action.* St. Louis, MO: Chalice Press.
Perkinson, R. (2000). *God Talks to You.* Bloomington, IN: 1stBooks.
Smedes, L. (2007). *Forgive and Forget: Healing the Hurts We Don't Deserve.* San Francisco: HarperOne.
Willard, D. (1990). *The Spirit of the Disciplines.* New York: Harper & Row.

Substance Abuse/Dependence

Alcoholics Anonymous World Services. (2001). *Alcoholics Anonymous.* New York: Alcoholics Anonymous World Services.
Daley, D. C., & Marlatt, G. A. (2006). *Overcoming Your Alcohol or Drug Problem: Effective Recovery Strategies Workbook.* New York: Oxford University Press.
Denning, P., Little, J., & Glickman, A. (2003). *Over the Influence: The Harm Reduction Guide for Managing Drugs and Alcohol*. New York: Guilford Press.
Inaba, D. S., & Cohen, W. E. (2001). *Uppers, Downers, All-Arounders.* Ashland, OR: CNS Productions.

Marlatt, G. A. (2002). *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*. New York: Guilford Press.

Miller, W. R., & Munoz, R. F. (2004). *Controlling Your Drinking: Tools to Make Moderation Work for You*. New York: Guilford Press.

Sales, P. (1999). *Alcohol Abuse: Straight Talk Straight Answers.* Honolulu, HI: Ixia Publications.

Solowji, N. (2006). *Cannabis and Cognitive Functioning.* New York: Cambridge University Press.

Washton, A., & Boundy, D. (1990). *Willpower's Not Enough: Understanding and Recovering from Addictions of Every Kind.* New York: HarperCollins.

Washton, A., & Zweben, J. (2009). *Cocaine and Methamphetamine Addiction: Treatment, Recovery, and Relapse Prevention.* New York: Norton.

Substance-Induced Disorders

Antony, M., & Swinson, R. (2008). *The Shyness & Social Anxiety Workbook: Proven, Step-by-Step Techniques for Overcoming Your Fears.* Oakland, CA: New Harbinger Publications.

Bourne, E. (2005). *The Anxiety & Phobia Workbook.* Oakland, CA: New Harbinger Publications.

Burns, D. (1999). *The Feeling Good Handbook.* New York: Plume.

Burns, D. (1999). *Ten Days to Self Esteem!* New York: Collins Living.

Copeland, M., & McKay, M. (2004). *The Depression Workbook: A Guide for Living with Depression and Manic Depression.* Oakland, CA: New Harbinger Publications.

Cronkite, K. (1995). *On the Edge of Darkness: Conversations About Conquering Depression.* New York: Delta.

Dayhoff, S. A. (2000). *Diagonally Parked in a Parallel Universe: Working Through Social Anxiety.* Placitas, NM: Effectiveness-Plus Publications.

Gilson, M., & Freeman, A. (2004). *Overcoming Depression: A Cognitive Therapy Approach for Taming the Depression BEAST Client Workbook.* New York: Oxford University Press.

Goldman, C., & Babior, S. (1996). *Overcoming Panic, Anxiety, & Phobias: New Strategies to Free Yourself from Worry and Fear.* Duluth, MN: Whole Person Associates.

O'Connor, R. (1999). *Undoing Depression: What Therapy Doesn't Teach You and Medication Can't Give You.* New York: Berkley Publishing Group.

Peurifoy, R. Z. (1995). *Anxiety, Phobias, and Panic: A Step-by-Step Program for Regaining Control of Your Life.* New York: Warner Books.

Rapee, R. M. (1999). *Overcoming Shyness and Social Phobia: A Step-by-Step Guide.* Northvale, NJ: Jason Aronson.

Yapko, M. (1998). *Breaking the Patterns of Depression.* New York: Main Street Books.

Substance Intoxication/Withdrawal

Alcoholics Anonymous World Services. (2001). *Alcoholics Anonymous.* New York: Alcoholics Anonymous World Services.

Alcoholics Anonymous World Services. (1981). *Twelve Steps and Twelve Traditions.* New York: Alcoholics Anonymous World Services.

Denning, P., Little, J., & Glickman, A. (2003). *Over the Influence: The Harm Reduction Guide for Managing Drugs and Alcohol.* New York: Guilford Press.

Fanning, P. (1996). *The Addiction Workbook: A Step-by-Step Guide to Quitting Alcohol and Drugs.* Oakland, CA: New Harbinger Publications.

May, G. (2007). *Addiction and Grace: Love and Spirituality in the Healing of Addictions.* San Francisco: HarperOne.

West, J., & Ford, B. (1997). *The Betty Ford Center Book of Answers: Help for Those Struggling with Substance Abuse and for the People Who Love Them.* New York: Pocket Books.

World Service Office. (1988). *Narcotics Anonymous.* Van Nuys, CA: World Service Office.

Suicidal Ideation

Arena, J. (1996). *Step Back from the Exit: 45 Reasons to Say No to Suicide.* Milwaukee, WI: Zebulon Press.

Burns, D. (1999). *The Feeling Good Handbook.* New York: Plume.

Burns, D. (1999). *Ten Days to Self Esteem!* New York: Collins Living.

Copeland, M., & McKay, M. (2004). *The Depression Workbook: A Guide for Living with Depression and Manic Depression.* Oakland, CA: New Harbinger Publications.

Cronkite, K. (1995). *On the Edge of Darkness: Conversations About Conquering Depression.* New York: Delta.

Ellis, T. E., & Newman, C. F. (1996). *Choosing to Live: How to Defeat Suicide Though Cognitive Therapy.* Oakland, CA: New Harbinger Publications.

Jamison, K. R. (2000). *Night Falls Fast: Understanding Suicide.* New York: Vintage Books.

O'Connor, R. (1999). *Undoing Depression: What Therapy Doesn't Teach You and Medication Can't Give You.* New York: Berkley Publishing Group.

Thorn, J., & Rothstein, L. (1993). *You Are Not Alone: Words of Experience and Hope for the Journey Through Depression.* New York: Harper Perennial.

Yapko, M. (1998). *Breaking the Patterns of Depression.* New York: Main Street Books.

Treatment Resistance

Alcoholics Anonymous World Services. (2001). *Alcoholics Anonymous.* New York: Alcoholics Anonymous World Services.

Alcoholics Anonymous World Services. (1981). *Twelve Steps and Twelve Traditions.* New York: Alcoholics Anonymous World Services.

Fanning, P. (1996). *The Addiction Workbook: A Step-by-Step Guide to Quitting Alcohol and Drugs.* Oakland, CA: New Harbinger Publications.

May, G. (2007). *Addiction and Grace: Love and Spirituality in the Healing of Addictions.* San Francisco: HarperOne.

Miller, W. R., & Munoz, R. F. (2004). *Controlling Your Drinking: Tools to Make Moderation Work for You*. New York: Guilford Press.

West, J. W., & Ford, B. (1997). *The Betty Ford Center Book of Answers: Help for Those Struggling with Substance Abuse and for the People Who Love Them.* New York: Pocket Books.

World Service Office. (1988). *Narcotics Anonymous.* Van Nuys, CA: World Service Office.

Appendix B

SELECTED PROFESSIONAL REFERENCES FOR EVIDENCE-BASED CHAPTERS

Evidence-based Psychological and Psychopharmacological Treatments in General

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61,* 271–285.

Bruce, T. J., & Sanderson, W. C. (2005). Evidence-based psychosocial practices: Past, present, and future. In C. Stout and R. Hayes (Eds.), *The Handbook of Evidence-Based Practice in Behavioral Healthcare: Applications and New Directions*. Hoboken, NJ: John Wiley & Sons.

Castonguay, L. G., & Beutler, L. E. (2006). *Principles of Therapeutic Change that Work.* New York: Oxford University Press.

Chambless, D. L., Baker, M. J., Baucom, D., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., Daiuto, A., DeRubeis, R., Detweiler, J., Haaga, D. A. F., Johnson, S. B., McCurry, S., Mueser, K. T., Pope, K. S., Sanderson, W. C., Shoham, V., Stickle, T., Williams, D. A., & Woody, S. R. (1998). Update on empirically validated therapies: II. *The Clinical Psychologist*, *51*(1), 3–16.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685–716.

Chambless, D. L., Sanderson, W. C., Shoham, V., Johnson, S. B., Pope, K. S., Crits-Christoph, P., Baker, M., Johnson, B., Woody, S. R., Sue, S., Beutler, L., Williams, D. A., & McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist*, *49*(2), 5–18.

Drake, R. E., & Goldman, H. (2003). *Evidence-based Practices in Mental Health Care.* Washington, D.C.: American Psychiatric Association.

Drake, R. E., Merrens, M. R., & Lynde, D. W. (2005). *Evidence-Based Mental Health Practice: A Textbook*. New York: W.W. Norton & Company.

Hofmann, S. G., & Tompson, M. G. (2002). *Treating Chronic and Severe Mental Disorders: A Handbook of Empirically Supported Interventions.* New York: Guilford Press.

Nathan, P. E., & Gorman, J. M. (Eds.) (2007). *A Guide to Treatments that Work,* 3rd ed. New York: Oxford University Press.

Personal Improvement Computer Systems. *Therapyadvisor*. Available online at http://www.therapyadvisor.com.

Society of Clinical Psychology, American Psychological Association Division 12. *Website on Research-supported Psychological Treatments*. Available online at http://www.psychology.sunysb.edu/eklonsky-/division12/index.html.

Stout, C., & Hayes, R. (1995). *The Handbook of Evidence-Based Practice in Behavioral Healthcare: Applications and New Directions*. Hoboken, NJ: John Wiley & Sons.

Substance Abuse and Mental Health Administration (SAMHSA). *National Registry of Evidence-based Programs and Practices (NREPP*). Available online at http://nrepp.samhsa.gov/index.asp.

Anger

Deffenbacher, J. L., Dahlen, E. R., Lynch, R. S., Morris, C. D., & Gowensmith, W. N. (2000). An application of Beck's cognitive therapy to general anger reduction. *Cognitive Therapy and Research, 24*, 687–689.

Deffenbacher, J. L., Oetting, E. R., Huff, M. E., & Cornell, G. R., Dallagher, C. J., et al. (1996). Evaluation of two cognitive-behavioral approaches to general anger reduction. *Cognitive Therapy and Research, 20*, 551–573.

Deffenbacher, J., Story, D., Brandon, A., Hogg, J., and Hazaleus, S. (1988). Cognitive and cognitive relaxation treatment of anger. *Cognitive Therapy and Research, 12*, 167–184.

DiGiuseppe, R., & Tafrate, R. C. (2003). Anger treatment for adults: A meta-analytic review. *Clinical Psychology: Science & Practice, 10*, 70–84.

Feindler, E., & Ecton, R. (1986). *Adolescent Anger Control: Cognitive-Behavioral Techniques*. New York: Pergamon Press.

Meichenbaum, D. (1985). *Stress Inoculation Training*. New York: Pergamon Press.

Meichenbaum, D. (1993). Stress inoculation training: A twenty-year update. In R. L. Woolfolk and P. M. Lehrer (Eds.), *Principles and Practices of Stress Management*. New York: Guilford Press.

Meichenbaum, D. (2001). *Treatment of Individuals with Anger Control Problems and Aggressive Behaviors: A Clinical Handbook.* Clearwater, FL: Institute Press.

Novaco, R. (1975). *Anger Control: The Development and Evaluation of an Experimental Treatment*. Lexington, MA: Lexington Books.

Novaco, R. (1976). The functions and regulation of the arousal of anger. *American Journal of Psychiatry, 133*, 1124–1128.

Novaco, R. (1977). A stress inoculation approach to anger management in the training of law enforcement officers. *American Journal of Community Psychology, 5*, 327–346.

Anxiety

Barlow, D. H., Allen, L. B., & Basden, S. L. (2007). Psychological treatments for panic disorders, phobias, and generalized anxiety disorder. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 351–394). New York: Oxford University Press.

Beck, A. T., & Emory, G. (1990). *Anxiety Disorders and Phobias: A Cognitive Perspective*. New York: Basic Books.

Bernstein, D. A., & Borkovec, T. D. (1973). *Progressive Relaxation Training*. Champaign, IL: Research Press.

Brown, T. A., DiNardo, P. A., and Barlow, D. H. (2006). *Anxiety Disorders Interview Schedule Adult Version (ADIS-IV): Client Interview Schedule.* New York: Oxford University Press.

Brown, T. A., O'eary, T., & Barlow, D. H. (2001). Generalized anxiety disorder. In D. H. Barlow (Ed.), *Clinical Handbook of Psychological Disorders: A Step-By-Step Treatment Manual*, 3rd ed. (pp. 154–208). New York: Guilford Press.

Chambless, D. L, Baker, M. J., Baucom, D., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., Daiuto, A., DeRubeis, R., Detweiler, J., Haaga, D. A. F., Johnson, S. B., McCurry, S., Mueser, K. T., Pope, K. S., Sanderson, W. C., Shoham, V., Stickle, T., Williams, D. A., & Woody, S. R. (1998). Update on empirically validated therapies: II. *The Clinical Psychologist*, *51*(1), 3–16.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685–716.

Craske, M. G., Barlow, D. H., & O'Leary, T. (2006). *Mastery of Your Anxiety and Panic – Therapist Guide*. New York: Oxford University Press.

Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy*, *28*, 487–495.

Roy-Byrne, P. P., & Cowley, D. S. (2007). Pharmacological treatments for panic disorder, generalized anxiety disorder, specific phobia, and social anxiety disorder. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 395–430). New York: Oxford University Press.

Rygh, J. L., & Sanderson, W. C. (2004). *Treating GAD*: *Evidence-Based Strategies, Tools, and Techniques*. New York: Guilford Press.

Attention-Deficit/Hyperactivity Disorder (ADHD)—Adolescent

American Academy of Child & Adolescent Psychiatry (1997). Practice parameters for the assessment and treatment of children, adolescents, and adults with attention deficit/hyperactivity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*, 85S–121S.

Barkley, R. A. (1998). *ADHD: A Handbook for Diagnosis and Treatment,* 2nd ed. New York: Guilford Press.

Castellanos, F. X. (1999). The psychobiology of attention-deficit/hyperactivity disorder. In H.C. Quay & A.E. Hogan (Eds.) *Handbook of Disruptive Behavior Disorders* (pp. 179–198). New York: Kluwer Academic/Plenum Publishers.

Chronis, A. M., Chacko, A., Fabiano, G. A., Wymbs, B. T., & Pelham, W. E. (2004). Enhancements to the behavioral parent training paradigm for families of children with ADHD: Review and future directions. *Clinical Child and Family Psychology Review, 7,* 1–27.

DuPaul, G. J., & Stoner, G. (2003). *ADHD in the Schools: Assessment & Intervention Strategies*. New York: Guilford Press.

Hinshaw, S. P., Klein, R. G., & Abikoff, H. B. (2007). Childhood attention-deficit/hyperactivity disorder: Nonpharmacological treatments and their combination with medication. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 3–27). New York: Oxford University Press.

Johnston, C., & Mash, E. J. (2001). Families of children with attention deficit hyperactivity disorder: Review and recommendations for future research. *Clinical Child & Family Psychology Review*, *4*, 183–207.

Lahey, B. B., Pelham, W. E., Stein, M. A., Loney, J., Trapani, C., Nugent, K., Kipp, H., Schmidt, E., Lee, S., Cale, M., Gold, E., Hartung, C., Willcutt, E., & Baumann, B. (1998). Validity of DSM-IV attention deficit/hyperactivity disorder for younger children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *37*, 695–702.

MTA Cooperative Group. (1999). A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Archives of General Psychiatry*, *56*, 1073–1086.

Paykina, N. L., & Greenhill, L. (2007). Pharmacological treatments for attention-deficit/hyperactivity disorder. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 29–70). New York: Oxford University Press.

Pelham, W. E. (1999). The NIMH Multimodal Treatment Study for ADHD: Just say yes to drugs alone? *Canadian Journal of Psychiatry*, *44*, 981–990.

Pelhams, W. E., & Fabiano, G. A. (2008). Evidence-based psychosocial treatment for ADHD: An update. *Journal of Clinical Child and Adolescent Psychology, 37,* 184–214.

Pelham, W. E., Fabiano, G. A., Gnagy, E. M., Greiner, A. R., & Hoza, B. (in press). Comprehensive psychosocial treatment for ADHD. In E. Hibbs and P. Jensen (Eds), *Psychosocial Treatments for Child and Adolescent Disorders: Empirically Based Strategies for Clinical Practice*.

Pelham, W. E., Jr., Wheeler, T., & Chronis, A. (1998). Empirically supported psychosocial treatments for attention deficit hyperactivity disorder. *Journal of Clinical Child Psychology*, *27*, 190–205.

Robin, A. L. (2000). *ADHD in Adolescents: Diagnosis & Treatment*. New York: Guilford Press.

Smith, B. H., Waschbusch, D. A., Willoughby, M. T., & Evans, S. (2000). The efficacy, safety, and practicality of treatments for adolescents with attention-deficit/hyperactivity disorder. *Clinical Child & Family Psychology Review*, *3*, 243–267.

Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology*, *62*, 583–593.

Attention-Deficit/Hyperactivity Disorder (ADHD)–Adult

Safren, S. A. (2006). Cognitive-behavioral approaches to ADHD treatment in adulthood. *Journal of Clinical Psychiatry*, *67*(8), 46–50.

Safren, S. A., Otto, M. W., Sprich, S, Winett, C. L., Wilens, T. E., & Biederman, J. (2005). Cognitive-behavioral therapy for ADHD in medication-treated adults with continued symptoms. *Behaviour Research and Therapy*. *43*(7), 831–842.

Safren, S. A., Sprich, S., Perlman, C. A., & Otto, M. W. (2005) *Mastery of Your Adult ADHD - Therapist Manual*. New York: Oxford University Press.

Weiss, M., Safren, S. A., Solanto, M., Hechtman, L., Rostain, A. L., Ramsay, R., & Murray, C. (2008). Research forum on psychological treatment of adults with ADHD. *Journal of Attention Disorders, 11*, 642–651.

Borderline Traits

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford Press.

Crits-Christoph, P., & Barber, J. P. (2007). Psychological treatments for personality disorders. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 641–658). New York: Oxford University Press.

Freeman, A. (2002). Cognitive behavioral therapy for severe personality disorders. In S. G. Hofmann and M. C. Tompson (Eds.). *Treating Chronic and Severe Mental Disorders: A Handbook of Empirically Supported Interventions* (pp. 382–402). New York: Guilford Press.

Koenigsberg, H. W., Woo-Ming, A. M., & Siever, L. J. (2007). Psychopharmacological treatment of personality disorders. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 659–680). New York: Oxford University Press.

Linehan, M., Cochran, & Kehrer, (2001). Dialectical Behavior Therapy for Borderline Personality Disorder. In D. H. Barlow (Ed.), *Clinical Handbook of Psychological Disorders: A Step-By-Step Treatment Manual,* 3rd ed. New York: Guilford Press.

Linehan, M., Dimeff, L. A., Koerner, K. (2007*). Dialectical Behavior Therapy in Clinical Practice: Applications Across Disorders and Settings*. New York: Guilford Press.

Linehan, M. M. (1993). *Cognitive Behavioral Treatment for Borderline Personality Disorder*. New York: Guilford Press.

Linehan, M. M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder*. New York: Guilford Press.

Linehan, M. M., Armstrong, H., Suarez, A. Allmon, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48,* 1060–1064.

Linehan, M. M., Heard, H. L., & Armstrong, H. E. (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry*, *50*, 971–974.

Linehan, M. M., Schmidt, H., Dimeff, L. A., Craft, J. C., Kanter, J., & Comtois, K. A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *American Journal on Addiction*, 8(4), 279–292.

Linehan, M. M., Tutek, D., Heard, H., & Armstrong, H. (1992). Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry, 151*(12)*,* 1771–1775.

Resick, P. A., & Calhoun, K. S., (2001). Posttraumatic Stress Disorder. In D. H. Barlow (Ed.), *Clinical Handbook of Psychological Disorders: A Step-By-Step Treatment Manual*, 3rd ed. New York: Guilford Press.

Safer, D. L., Telch, C. F., & Agras, W. S. (2001). Dialectical behavior therapy for bulima nervosa. *American Journal of Psychiatry*, *158*(4), 632–634.

Whitehurst, T., Ridolfi, M. E., & Gunderson, J. (2002). Multiple family group treatment for borderline personality disorder. In S. G. Hofmann and M. C. Tompson (Eds.), *Treating Chronic and Severe Mental Disorders: A Handbook of Empirically Supported Interventions* (pp. 343–363). New York: Guilford Press.

Childhood Trauma

AACAP. (1998). Summary of the practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. American Academy of Child and Adolescent Psychiatry. *Journal of the American Academy of Child and Adolescent Psychiatry*, *37*, 997–1001.

Amaya-Jackson, L., Reynolds, V., Murray, M., McCarthy, G., Nelson, A., Cherney, M., et al. (2003). Cognitive behavioral treatment for pediatric posttraumatic stress disorder: Protocol and application in school and community settings. *Cognitive and Behavioral Practice, 10*, 204–213.

Cohen, J., Berliner, L., & March, J. (2000). Treatment of PTSD in Children and Adolescents: Guidelines. In E. Foa, J. Davidson, and T. Keane (Eds.), *Effective Treatments for PTSD* (pp. 330–332). New York: Guilford Press.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents*. New York: Guilford Press.

Davidson, J., & March, J. (1996). Traumatic stress disorders. In A. Tasman, J. Kay, and J. Lieberman (Eds.), *Psychiatry, Vol. 2* (pp. 1085–1098). Philadelphia: Saunders.

Deblinger, E., & Heflin, A. H. (1996). *Treatment for Sexually Abused Children and their Non-offending Parents: A Cognitive-behavioral Approach*. Thousand Oaks, CA: Sage.

Donnelly, C., Amaya-Jackson, L., & March, J. (1999) Psychopharmacology of pediatric posttraumatic stress disorder. *Journal of Child Adolescent Psychopharmacology, 9*, 203–220.

Foa, E. B., Keane, T. M., & Friedman, M. J. (2004). *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*. New York: Guilford Press.

Foa, E. B., & Meadows, E. A. (1997), Psychosocial treatments for posttraumatic stress disorder: A critical review. *Annual Review of Psychology, 48*, 449–480.

Foy, D. W. (Ed.) (1992). Treating PTSD: Cognitive Behavioral Strategies. New York: Guilford Press.

Francis, G., & Beidel, D. (1995). Cognitive Behavioral Psychotherapy. In J. March (Ed.), *Anxiety Disorders in Children and Adolescents.* pp. 321–340 New York: Guilford Press.

March, J., Amaya-Jackson, L., Murray, M., & Schulte, A. (1998). Cognitive-behavioral psychotherapy for children and adolescents with post-traumatic stress disorder following a single incident stressor. *Journal of the American Academy of Child and Adolescent Psychiatry*. *37*, 585–593.

Meichenbaum, D. A. (1995). *Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults with Post-Traumatic Stress Disorder (PTSD*). Institute Press.

Nader, K., Blake, D., Kriegler, J., & Pynoos, R. (1994). *Clinician Administered PTSD Scale for Children (CAPS-C), Current and Lifetime Diagnosis Version, and Instruction Manual.* UCLA Neuropsychiatric Institute and National Center for PTSD.

Najavits, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

Resick, P. A., & Calhoun, K. S. (2001). Posttraumatic Stress Disorder. In D. H. Barlow (Ed.), *Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual,* 3rd ed*.* New York: Guilford Press.

Rothbaum, B. O., & Foa, E. B. (2004). *Reclaiming Your Life After Rape: Cognitive-Behavioral Therapy for Posttraumatic Stress Disorder – Client Workbook.* New York: Oxford University Press.

Saunders, B. E., & Hanson, R. F. (Eds). (2002) *Child Physical and Sexual Abuse: Guidelines for Treatment*. Charleston, SC: Authors.

Silverman, W. K., & Albano, A. M. (1996). *The Anxiety Disorders Interview Schedule for DSM-IV: Child Interview Schedule*. Boulder, CO: Graywind.

Solomon, S. D., Gerrity, E. T., & Muff, A. M. (1992), Efficacy of treatments for posttraumatic stress disorder. An empirical review. *Journal of the American Medical Association*, 268, 633–638.

Chronic Pain

Bradley, L. A., Young, L. D., Anderson, J. O., Turner, R. A., Agudelo, C. A., McDaniel, L. K., Pisko, E. J., Semble, E. J., & Morgan, T. M. (1987). Effects of psychological therapy on pain behavior of rheumatoid arthritis patients: Treatment outcome and six-month follow-up. *Arthritis & Rheumatism, 30,* 1105–1114.

Guzman, J., Esmail, R., Karjalainen, K., Malmivaara, A., Irvin, E., & Bombardier, C. (2001). Multidisciplinary bio-psycho-social rehabilitation for chronic low back pain. *The Cochrane Database of Systematic Reviews, 1,* Art No.: CD000963.

Hoffman, B. M., Chatkoff, D. K., Papas, R. K., & Kerns, R. D. (2007). Meta-analysis of psychological interventions for chronic low back pain. *Health Psychology, 26*, 1–9.

Keefe, F. J., Beaupre, P. M., Gil, K. M., Rumble, M. E., & Aspnes, A. K. (2002). Group therapy for patients with chronic pain. In D. C. Turk and R. J. Gatchel (Eds.) *Psychological Approaches to Pain Management: A Practitioner's Handbook,* 2nd ed. New York: Guilford Press.

Keefe, F. J., Caldwell, D. S., Williams, D. A., Gil, K.M., Mitchell, D., Robertson, D., Robertson, C., Martinez, S., Nunley, J., Beckham, J. C., & Helms, M. (1990). Pain coping skills training in the management of osteoarthritic knee pain: A comparative study. *Behavior Therapy, 21,* 49–62.

Keefe, F. J., & Gil, K. M. (1986). Behavioral concepts in the analysis of chronic pain syndromes. *Journal of Consulting and Clinical Psychology, 54,* 776–783.

Ostelo, R. W., Van Tulder, M. W., Vlaeyan, J. W., Linton, S. J., Morley, S. J., & Assendelft, W. J. (2005). Behavioral treatment for chronic low back pain (Review). *The Chochrane Library*, *4*, 1–25.

Syrjala, K. L., Donaldson, G. W., Davies, M. W., Kippes, M. E., & Carr, J. E. (1995). Relaxation and imagery and cognitive-behavioral training reduce pain during cancer treatment: A controlled clinical trial. *Pain, 63,* 189–198.

Turk, D. C., Meichenbaum, D., & Genest, M. (1983). *Pain and Behavioral Medicine: A Cognitive-behavioral Perspective.* New York: Guilford Press.

Turner, J. A., & Clancy, S. (1988). Comparison of operant-behavioral and cognitive-behavioral group treatment for chronic low back pain. *Journal of Consulting and Clinical Psychology, 58,* 573–579.

Conduct Disorder/Delinquency

Alexander, J. F., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81*, 219–225.

Bernstein, D. A., Borkovec, T. D., & Hazlett-Stevens, H. (2000). *New Directions in Progressive Relaxation Training: A Guidebook for Helping Professionals*. Westport, CT: Praeger.

Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multi-systemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology, 63*, 569–578.

Brestan, E. V., & Eyberg, S. M. (1998). Effective psychosocial treatments of conduct disorders children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology, 27*, 180–189.

Curtis, N. M., Ronan, K. R., & Borduin, C. M. (2004). Multisystemic treatment: A meta-analysis of outcome studies. *Journal of Family Psychology, 18*, 411–419.

Feindler, E. L., Marriott, S. A., & Iwata, M. (1984). Group anger control training for junior high school delinquents. *Cognitive Therapy & Research, 8*, 299–311.

Henggeler, S. W., Melton, G. B., & Smith, L. A. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting & Clinical Psychology, 60*, 953–961.

Henggeler, S. W., Rodick, J. D., Bourdin, C. M., Hanson, C. L., Watson, S. M., & Urey, J. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behavior and family interaction. *Developmental Psychology, 22*, 132–141.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*. New York: Guilford Press.

Huey, W. C., & Rank, R. C. (1984). Effects of counselor and peer-led group assertiveness training on black adolescent aggression. *Journal of Counseling Psychology, 31*, 95–98.

Kazdin, A. (2007). Psychosocial treatments for conduct disorder in children and adolescents. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 71–104). New York: Oxford University Press.

Kazdin, A. E., Esveldt-Dawson, K., French, N. H., & Unis, A. S. (1987a). Problem-solving skills training and relationship therapy in the treatment of antisocial child behavior. *Journal of Consulting & Clinical Psychology, 55*, 76–85.

Kazdin, A. E., Esveldt-Dawson, K., French, N. H., & Unis, A. S. (1987b). Effects of parent management training and problem-solving skills training combined in the treatment of antisocial child behavior. *Journal of the American Academy of Child & Adolescent Psychiatry, 26*, 416–424.

Kazdin, A. E., Siegel, T. C., & Bass, D. (1992). Cognitive problem-solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting & Clinical Psychology, 60*, 733–747.

Lochman, J. E., Lampron, L. B., Gemmer, T. C., Harris, S. R., & Wyckoff, G. M. (1989). Teacher consultation and cognitive-behavioral interventions with aggressive boys. *Psychology in the Schools, 26*, 179–188.

Meichenbaum, D. (1985). *Stress Inoculation Training.* New York: Pergamon Press.

Meichenbaum, D. (1993). Stress inoculation training: A twenty-year update. In R. L. Woolfolk and P. M. Lehrer (Eds.), *Principles and Practices of Stress Management*. New York: Guilford Press.

Meichenbaum, D. (2001). *Treatment of Individuals with Anger Control Problems and Aggressive Behaviors: A Clinical Handbook.* Clearwater, FL: Institute Press.

Novaco, R. (1975). *Anger Control: The Development and Evaluation of an Experimental Treatment*. Lexington, MA: Lexington Books.

Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology, 62*, 583–593.

Depression

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford Press.

Beck, A. T., & Steer, R. A., (1988). *Beck Hopelessness Scale*. San Antonio, TX: The Psychological Corporation.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory Manual,* 2nd ed. San Antonio, TX: The Psychological Corporation.

Beck, J. S. (1995). *Cognitive Therapy: Basics and Beyond*. New York: Guilford Press.

Bowman, D., Scogin, F., & Lyrene, B. (1995). The efficacy of self-examination and cognitive bibliotherapy in the treatment of mild to moderate depression. *Psychotherapy Research, 5*, 131–140.

Craighead, W. E., Sheets, E. S., Brosse, A. L., & Ilardi, S. S. (2007). Psychosocial treatments for major depressive disorder. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 289–307). New York: Oxford University Press.

Klerman, G. L., Weissman, M. M., Rounasacille, B. J., & Chevron, E. S. (1984). *Interpersonal Psychotherapy of Depression*. New York: Basic Books.

Lewinson, P. M. (1974) A behavioural approach to depression. In R. J. Friedman and Katz (Eds.), *The Psychology of Depression*. Washington, D.C.: Winston & Sons.

Lewinsohn, P. M., Antonuccio, D. O., Steinmetz, J. L., & Teri, L. (1984). *The Coping with Depression Course: A Psychoeducational Intervention for Unipolar Depression*. Eugene, OR: Castalia.

Nemeroff, C. B., & Schatzberg, A. F. (2007). Pharmacological treatments for unipolar depression. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 271–287). New York: Oxford University Press.

Nezu, A. M., Nezu, C. M., & Perri, M. G. (1989). *Problem-Solving Therapy for Depression: Theory, Research, and Clinical Guidelines*. Hoboken, NJ: John Wiley & Sons.

Scogin, F., Jamison, C., & Gochneaur, K. (1989). Comparative efficacy of cognitive and behavioral bibliotherapy for mildly and moderately depressed adults. *Journal of Consulting and Clinical Psychology, 57*, 403–407.

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive Guide to Interpersonal Psychotherapy*. New York: Basic Books.

Zimmerman, M., Coryell, W., Corenthal, C., & Wilson, S. (1986). A self-report scale to diagnose major depressive disorder. *Archives of General Psychiatry, 43*, 1076–1081.

Eating Disorders

Agras, W. S., Walsh, B. T., Fairburn, C. G., Wilson, G. T., & Kreamer, H. C. (2000). A multicenter comparison of cognitive-behavioural therapy and interpersonal psychotherapy for bulimia nervosa. *Archives of General Psychiatry, 57*, 459–466.

Fairburn, C. G. (2008). *Cognitive Behavior Therapy and Eating Disorders*. New York: Guilford Press.

Fairburn, C. G., & Carter, J. C. (1997). Self-help and guided self-help for binge-eating problems. In D. M. Garner and P. E. Garfinkel (Eds.). *Handbook of Treatment for Eating Disorders* (pp. 494–499). New York: Guilford Press.

Fairburn, C. G., Jones, R., Peveler, R. C., Carr, S. J., Solomon, R. A., O'Conner, M. E., Burton, J., & Hope, R. A. (1991). Three psychological treatments for bulimia nervosa: A comparative trial. *Archives of General Psychiatry, 48*, 463–469.

Fairburn, C. G., Marcus, M. D., & Wilson, G. T. (1993). Cognitive-behavioral therapy for binge eating and bulimia nervosa. In C. G. Fairburn and G. T. Wilson (Eds.), *Binge Eating: Nature, Assessment, and Treatment*. New York: Guilford Press.

Wilson, G. T., & Fairburn, C. G. (2007). Treatments for eating disorders. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 579–609). New York: Oxford University Press.

Family Conflicts

Azrin, N. H., Aciemo, R., Kogan, E. S., Donohue, B., Basalel, V.A., & McMahon, P. T. (1996). Follow-up results of supportive versus behavioral therapy for illicit drug use. *Behavior Research and Therapy, 34,* 41–46.

Azrin, N. H., Donohue, B., Besalel, V. A., Kogan, E. S., & Acierno, R. (1994). Youth drug abuse treatment: A controlled outcome study. *Journal of Child and Adolescent Substance Abuse, 3*, 1–15.

Azrin, N. H., Donohue, B., Teichner, G. A., Crum, T., Howell, J., & DeCato, L. A. (2001). A controlled evaluation and description of individual-cognitive problem solving and family-behavior therapies in dually diagnosed conduct-disordered and substance-dependent youth. *Journal of Child and Adolescent Substance Abuse, 11*, 1–41.

Azrin, N. H., McMahon, P. T., Donohue, B., Besalel, V. A., Lapinski, K. J., Kogan, E. S., et al. (1994). Behavior therapy for drug abuse: A controlled treatment outcome study. *Behaviour Research and Therapy, 32*, 857–866.

Donohue, B., & Azrin, N. (2001). Family behavior therapy. In E. Wagner and H. Waldron (Eds.), *Adolescent Substance Abuse Intervention* (pp. 205–227). Oxford, UK: Elsevier Science, Ltd.

Donohue, B., & Azrin, N. H. (2002). Family behavior therapy in a conduct-disordered and substance-abusing adolescent: A case example. *Clinical Case Studies, 1*, 299–323.

Gambling

Echeburua, E., Baez, C., & Fernandez-Montalvo, J. (1996). Comparative effectiveness of three therapeutic modalities in psychological treatment of pathological gambling: Long-term outcome. *Behavioral and Cognitive Psychotherapy, 24*, 51–72.

Grant, J. E., & Potenza, M. N. (2007). Treatments for pathological gambling and other impulse control disorders. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work,* 3rd ed. New York: Oxford University Press.

Whelan, J. P., Steenbergh, T. A., & Meyers, A. W. (2007). *Problem and Pathological Gambling*. Cambridge, MA: Hogrefe and Huber Publishers.

Mania/Hypomania

Falloon, I. R. G., Boyd, J. L., & McGill, C. W. (1984). *Family Care of Schizophrenia: A Problem-Solving Approach to the Treatment of Mental Illness*. New York: Guilford Press.

Keck, P. E., Jr., & McElroy, S. L. (2007). Pharmacological treatments for bipolar disorder. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 323–350). New York: Oxford University Press.

Miklowitz, D. J. (2001). Bipolar Disorder. In D. H. Barlow (Ed.), *Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual*, 3rd ed. New York: Guilford Press.

Miklowitz, D. J. (2008). *Bipolar Disorder: A Family-Focused Treatment Approach* 2nd ed. New York: Guilford Press.

Miklowitz, D. J., & Craighead, W. E. (2007). Psychosocial treatments for bipolar disorder. In P. E. Nathan and J. M. Gorman (Eds*.), A Guide to Treatments that Work*, 3rd ed. (pp. 309–322). New York: Oxford University Press.

Miklowitz, D. J., George, E. L., Richards, J. A., Simoneau, T. L., & Suddath, R. L. (2003). A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry*, *60*, 904–912.

Miklowitz, D. J., & Goldstein, M. J. (1997). *Bipolar Disorder: A Family-Focused Treatment Approach*. New York: Guilford Press.

Miklowitz, D. J., & Hooley, J. M. (1998). Developing family psychoeducational treatments for patients with bipolar and other severe psychiatric disorders. *Journal of Marital and Family Therapy*, *24*(4), 419–435.

Miklowitz, D. J., Simoneau, T. L., George, E. L., Richards, J. A., Kalbag, A., Sachs-Ericcson, N., & Suddath, R. (2000). Family-focused treatment of bipolar disorder: One-year effects of a psychoeducational program in conjunction with pharmacotherapy. *Biological Psychiatry*, *48*, 582–592.

Otto, M., & Reilly-Harrington, (2002). Cognitive Behavioral Therapy for the Management of Bipolar Disorder. In S. G. Hofmann and M. C. Tompson (Eds). *Treating Chronic and Severe Mental Disorders: A Handbook of Empirically Supported Interventions*. New York: Guilford Press.

Perry, A., Tarrier, N., Morris, R., McCarthy, E., & Limb, K. (1999). Randomised controlled trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment. *British Medical Journal*, *318*, 149–153.

Rea, M. M., Tompson, M., Miklowitz, D. J., Goldstein, M. J., Hwang, S., & Mintz, J. (2003). Family focused treatment vs. individual treatment for bipolar disorder: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *71*, 482–492.

Simoneau, T. L., Miklowitz, D. J., Richards, J. A., Saleem, R., & George, E. L. (1999). Bipolar disorder and family communication: Effects of a psychoeducational treatment program. *Journal of Abnormal Psychology*, *108*, 588–597.

Wendel, J. S., Miklowitz, D. J., Richards, J. A., & George, E. L. (2000). Expressed emotion and attributions in the relatives of bipolar patients: An analysis of problem-solving interactions. *Journal of Abnormal Psychology*, *109*, 792–796.

Yahne, C. E., & Miller, W. R. (1999). Enhancing motivation for treatment and change. In B. S. McCrady and E. E. Epstein (Eds.). *Addictions: A Comprehensive Guidebook* (pp. 235–249). New York: Oxford University Press.

Nicotine Abuse/Dependence

Agency for Healthcare Research and Quality. (2008). *AHCPR-supported Clinical Practice Guidelines: Treating Tobacco Use and Dependence (2008 update).* Available online at: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.28163.

Occupational Problems

Bond, G. R. (2004). Supported employment: Evidence for an evidence-based practice. *Psychiatric Rehabilitation Journal, 27*, 345–359.

Salyers, M. P., Becker, D. R., Drake, R. E., Torrey, W. C., & Wyzik, P. F. (2004). Ten-year follow-up of clients in a supported employment program. *Psychiatric Services, 55*, 302–308.

Opioid Dependence

Abbot, P. J., Weller, S. B., Delaney, H. D., & Moore, B. A. (1998). Community reinforcement approach in the treatment of opiate addicts. *American Journal of Drug and Alcohol Abuse, 24*(1)*,* 17–30.

Finney, J. W., Wilbourne, P. L., & Moos, R. H. (2007). Psychosocial treatments for substance use disorders. In P. E. Nathan and J. M. Gorman (Eds.). *A Guide to Treatments that Work,* 3rd ed. (pp. 179–202). New York: Oxford University Press.

Marlatt, G. A., & Donovan, D. M. (Eds.) (2005). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors,* 2nd ed*.* New York: Guilford Press.

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors*. New York: Guilford Press.

McCrady, B. S., & Nathan, P. E. (2006). Treatment factors in treating substance use disorders. In L. G. Castonguay and L. E. Beutler (Eds.). *Principles of Therapeutic Change That Work* (pp. 319–340). New York: Oxford University Press.

Miller, W. R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change,* 2nd ed*.* New York: Guilford Press.

O'Brien, C. P. & McKay J. (2007). Psychopharmacological treatments for substance use disorders. In P. E. Nathan and J. M. Gorman (Eds.). *A Guide to Treatments That Work*, 3rd ed. (pp. 145–177). New York: Oxford University Press.

Ouimette, P. C., Finney, J. W., & Moos, R. H. (1997). Twelve step and cognitive-behavioral treatment for substance abuse: A comparison of treatment effectiveness. *Journal of Consulting and Clinical Psychology, 65*, 230–240.

Oppositional Defiant Disorder

Bernstein, D. A., Borkovec, T. D., & Hazlett-Stevens, H. (2000). *New Directions in Progressive Relaxation Training: A Guidebook for Helping Professionals*. Westport, CT: Praeger.

Block, J. (1978). Effects of a rational-emotive mental health program on poorly achieving disruptive high school students. *Journal of Counseling Psychology, 25*, 61–65.

Feindler, E. L., Marriott, S. A., & Iwata, M. (1984). Group anger control training for junior high school delinquents. *Cognitive Therapy & Research, 8*, 299–311.

Garner, D. M. (1991). *Eating Disorders Inventory-2*. Odessa, FL: Psychological Assessment Resources.

Huey, W. C., & Rank, R. C. (1984). Effects of counselor and peer-led group assertiveness training on black adolescent aggression. *Journal of Counseling Psychology, 31*, 95–98.

Kazdin, A. E., Esveldt-Dawson, K., French, N. H., & Unis, A. S. (1987a). Problem-solving skills training and relationship therapy in the treatment of antisocial child behavior. *Journal of Consulting & Clinical Psychology, 55*, 76–85.

Kazdin, A. E., Esveldt-Dawson, K., French, N. H., & Unis, A. S. (1987b). Effects of parent management training and problem-solving skills training combined in the treatment of antisocial child behavior. *Journal of the American Academy of Child & Adolescent Psychiatry, 26*, 416–424.

Kazdin, A. E., Siegel, T. C., & Bass, D. (1992). Cognitive problem-solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting & Clinical Psychology, 60*, 733–747.

Lochman, J. E., Lampron, L. B., Gemmer, T. C., Harris, S. R., & Wyckoff, G. M. (1989). Teacher consultation and cognitive-behavioral interventions with aggressive boys, *Psychology in the Schools, 26*, 179–188.

Meichenbaum, D. (1985). *Stress Inoculation Training*. New York: Pergamon Press.

Meichenbaum, D. (1993). Stress inoculation training: A twenty-year update. In R. L. Woolfolk and P. M. Lehrer (Eds.), *Principles and Practices of Stress Management*. New York: Guilford Press.

Meichenbaum, D. (2001). *Treatment of Individuals with Anger Control Problems and Aggressive Behaviors: A Clinical Handbook.* Clearwater, FL: Institute Press.

Novaco, R. (1975). *Anger Control: The Development and Evaluation of an Experimental Treatment*. Lexington, MA: Lexington Books.

Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology, 62*, 583–593.

Parent-Child Relational Problem

Brestan, E. V., & Eyberg, S. M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology, 27*, 180–189.

Forgatch, M. S., & DeGarmo, D. S. (1999). Parenting through change: An effective prevention program for single mothers. *Journal of Consulting and Clinical Psychology, 67*, 711–724.

Graziano, A. M., & Diament, D. M. (1992). Parent behavioral training: An examination of the paradigm. *Behavior Modification, 16*, 3–38.

Kazdin, A. E., (1997). Parent management training: Evidence, outcomes, and issues. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 1349–1356.

Long, P., Forehand, R., Wierson, M., & Morgan, A. (1994). Does parent training with young noncompliant children have long-term effects? *Behaviour Research and Therapy, 32*, 101–107.

Patterson, G. R., Dishion, T. J., & Chamberlain, P. (1993). Outcomes and methodological issues relating to treatment of antisocial children. In T. R. Giles (Ed.). *Handbook of Effective Psychotherapy* (pp. 43–87). New York: Plenum Press.

Sanders, M. R., & Dadds, M. R. (1993). *Behavioral Family Intervention.* Needham Heights, MA: Allyn & Bacon.

Serketich, W. J., & Dumas, J. E. (1996). The effectiveness of behavioral parent training to modify antisocial behavior in children: A meta-analysis. *Behavior Therapy, 27*, 171–186.

Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology, 62*, 583–593.

Partner Relational Conflicts

Baucom, D. H., Shoham, V. M., Kim, T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology, 66*(1), 53–88.

Christensen, A., & Heavey, C. L. (1999). Interventions for couples. *Annual Review of Psychology, 50*, 165–190.

Holtzworth-Munroe, A. S., & Jacobson, N. S. (1991). Behavioral marital therapy. In A. S. Gurman and D. P. Knickerson (Eds.), *Handbook of Family Therapy,* 2nd ed. (pp. 96–133). New York: Brunner/Mazel.

Jacobson, N. S., & Addis, M. E. (1993). Research on couple therapy: What do we know? Where are we going? *Journal of Consulting and Clinical Psychology, 61*, 85–93.

Jacobson, N. S., & Christensen, A. (1996). *Integrative Couple Therapy: Promoting Acceptance and Change.* New York: Norton.

Jacobson, N. S., Christensen, A., Prince, S. E., Cordova, J., & Eldridge, K. (2000). Integrative behavioral couple therapy: An acceptance-based, promising new treatment for couple discord. *Journal of Consulting and Clinical Psychology*, *68*(2), 351–355.

Jacobson, N. S., & Gottman, J. (1998). *When Men Batter Women: New Insights into Ending Abusive Relationships.* New York: Simon & Schuster.

Jacobson, N. S., & Margolin, G. (1979). *Marital Therapy: Strategies based on Social Learning and Behavior Exchange Principles.* New York: Brunner/Mazel.

Jacobson, N. S., Schmaling, K. B., & Holtzworth-Munroe, A. (1987). Component analysis of behavioral marital therapy: Two-year follow-up and prediction of relapse. *Journal of Marital and Family Therapy, 13*, 187–195.

Synder, D. K. (1997). *Marital Satisfaction Inventory – Revised.* Los Angeles: Western Psychological Services.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38*, 15–28.

Posttraumatic Stress Disorder (PTSD)

Bryant, R. A., & Harvey, A. G. (2000). *Acute Stress Disorder: A Handbook of Theory, Assessment, and Treatment*. Washington, D.C.: American Psychological Association.

Dunmore, E., Clark, D. M., & Ehlers, A. (2001). A prospective investigation of the role of cognitive factors in persistent Posttraumatic Stress Disorder (PTSD) after physical or sexual assault. *Behaviour Research and Therapy, 39*, 1063–1084.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*, 319–345.

Falsetti, S. A., & Resnick, H. S. (2001). Posttraumatic stress disorder. In W. J. Lyddon and J. V. Jones, Jr. (Eds.), *Empirically Supported Cognitive Therapies: Current and Future Applications* (pp. 182–199). New York: Springer.

Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A., & Street, G. (1999). A comparison of exposure therapy, stress inoculation training and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67*, 194–200.

Foa, E. B., Hembree, E. A , & Rothbaum, B. O. (2007). *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences, Therapist's Guide*. Oxford University Press: New York.

Foa, E. B., Keane, T. M., & Friedman, M. J. (2004). *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*. New York: Guilford Press.

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the Trauma of Rape: Cognitive-Behavioral Therapy for PTSD*. New York: Guilford Press.

Foy, D. W. (Ed.) (1992). *Treating PTSD: Cognitive Behavioral Strategies*. New York: Guilford Press.

Golier, J. A., Legge, J., & Yehuda, R. (2007). Pharmacological treatment of posttraumatic stress disorder. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments That Work*, 3rd ed. (pp. 475–512). New York: Oxford University Press.

Marks, I., Lovell, K., Noshirvani, H., et al., (1998). Treatment of post-traumatic stress disorder by exposure and/or cognitive restructuring: A controlled study. *Archives of General Psychiatry, 55*, 317–325.

McNally, R. J. (2003). *Remembering Trauma*. Cambridge, MA: Harvard University Press.

Meichenbaum, D. A. (1995). *Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults with Post-Traumatic Stress Disorder (PTSD)*. Institute Press.

Najavits, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

Najavits, L. M. (2007). Psychosocial treatments for posttraumatic stress disorder. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments That Work,* 3rd ed. (pp. 513–530). New York: Oxford University Press.

Padesky, C. A., Candido, D., Cohen, A., Gluhoski, V., McGinn, L. K., Sisti, M., & Westover, S. (2002). *Academy of Cognitive Therapy's Trauma Task Force Report*. Available online at: http://academyofct. org

Resick, P. A., & Calhoun, K. S. (2001). Posttraumatic Stress Disorder. In D. H. Barlow (Ed.), *Clinical Handbook of Psychological Disorders: A Step-By-Step Treatment Manual,* 3rd ed. New York: Guilford Press.

Resick, P. A., & Schnicke, M. K. (1996). *Cognitive Processing Therapy for Rape Victims: A Treatment Manual*. Newbury Park, CA: Sage Publications.

Wilson, J. P., Friedman, M. J., & Lindy, J. D. (2001). *Treating Psychological Trauma and PTSD.* New York: Guilford Press.

Wilson, J. P., & Keane, T. M. (Eds.) (1997). *Assessing Psychological Trauma and PTSD*. New York: Guilford Press.

Yule, W. (Ed.) (1999). *Post-Traumatic Stress Disorders: Concepts and Therapy*. Hoboken, NJ: John Wiley & Sons.

Psychosis

Bebbington, P., & Kuipers, L. (1994). The predictive utility of expressed emotion in schizophrenia: An aggregate analysis. *Psychological Medicine, 24*, 707–718.

Falloon, I. R. H. (2002). Cognitive-behavioral family and educational interventions for schizophrenic disorders. In S. G. Hofmann and M. G. Thompson (Eds.), *Treating Chronic and Severe Mental Disorders* (pp. 3–17). New York: Guilford Press.

Falloon, I. R. H., Boyd, J., & McGill, C. (1984). *Family Care of Schizophrenia.* New York: Guilford Press.

Falloon, I. R. H., & Penderson, J. (1985). Family management in the prevention of morbidity of schizophrenia: The adjustment of the family unit. *Archives of General Psychiatry, 147*, 156–163.

Hogarty, G. E. (2002). *Personal Therapy: A Guide to the Individual Treatment of Schizophrenia and Related Disorders.* New York: Guilford Press.

Hogarty, G. E., Anderson, C. M., Reiss, D. J., Kornblith, S. J., Greenwald, D. P., Javna, C. D., et al. (1986). Family psychoeducation, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia: I. One-year effects of a controlled study on relapse and expressed emotion. *Archives of General Psychiatry*, *34*, 633–642.

Hogarty, G. E., Anderson, C. M., Reiss, D. J., Kornblith, S. J., Greenwald, D. P., Ulrich, R. F., et al. (1991). Family psychoeducation, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia: II. Two-year effects of a controlled study on relapse and adjustment. *Archives of General Psychiatry, 48,* 340–347.

Hogarty, G. E., Greenwald D., Ulrich, R. F., Kornblith, S. J., DiBarry, A. L., Cooley, S., Carter, M., & Flesher, S. (1997). Three-year trials of personal therapy among schizophrenic patients living with or independent of family: II. Effects on adjustment of patients. *American Journal of Psychiatry, 154*(11), 1514–1524.

Hogarty, G. E. Kornblith, S. J., Greenwald, D., DiBarry, A. L., Cooley, S., Ulrich, R., Carter, M. & Flesher, S. (1997). Three-year trials of personal therapy among schizophrenic patients living with or independent of family: I. Description of study and effects on relapse rates. *American Journal of Psychiatry, 154*(11), 1504–1513.

Kopelowicz, A., Lieberman, R. P. & Zarate, R. (2007). Psychosocial treatments for schizophrenia. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 243–269). New York: Oxford University Press.

Kuipers, E., Garety, P., Fowler, D., Chisholm, D., Freeman, D., Dunn, G., Bebbington, P., & Hadley, C. (1998). London-East Anglia randomized controlled trial of cognitive-behavioural therapy for psychosis: III. Follow-up and economic evaluation at 18 months. *British Journal of Psychiatry, 173*, 61–68.

Kuipers, E., Garety., Fowler, D., Dunn, G., Bebbington, P., Freeman, D., & Hadley, C. (1997). London-East Anglia randomised controlled trial of cognitive-behavioural therapy for psychosis: I. Effects of the treatment phase. *British Journal of Psychiatry, 171*, 319–327.

Leff, J. (1994). Working with families of schizophrenic consumers. *British Journal of Psychiatry, 164*(Suppl. 23), 71–76.

Leff, J. Berkowitz, R., Shavit, N., Strachan, A., Glass, I., & Vaughn, C. (1989). A trial of family therapy v. a relatives group for schizophrenia. *British Journal of Psychiatry, 154,* 58–66.

Leff, J. Berkowitz, R., Shavit, N., Strachan, A., Glass, I., & Vaughn, C. (1990). A trial of family therapy v. a relatives group for schizophrenia: two-year follow-up. *British Journal of Psychiatry, 157*, 571–577.

Lehman, A. F., Steinwachs, D. M., Buchanan, R., Carpenter, W. T., Dixon, L. B., Fahey, M., et al. (1998). Translating research into practice: The Schizophrenia Consumer Outcomes Research Team (PORT) treatment recommendations. *Schizophrenia Bulletin, 24*, 1–10.

Lewis, S., Tarrier, N., Haddock, G., Bentall, R., Kinderman, P., Kingdon, P., & the SOCRATES Group. (2002). A randomised trial of cognitive behaviour therapy in early schizophrenia: Acute phase outcomes. *British Journal of Psychiatry, 181,* 91–97.

McFarlane, W. R. (2002). Empirical studies of outcome in multifamily groups. In W. R. McFarlane (Ed.), *Multifamily Groups in the Treatment of Severe Psychiatric Disorders* (pp. 49–70). New York: Guilford Press.

McFarlane, W. R., Dixon, L., Lukens, E., & Lucksted, A. (2003). Family psychoeducation and schizophrenia: A Review of the literature. *Journal of Marital and Family Therapy. 29*, 223–245.

McFarlane, W. R., Lukens, E., Link, B., Dushay, R., Deakins, S. A., Newmark, M., et al. (1995). Multiple-family groups and psychoeducation in the treatment of schizophrenia. *Archives of General Psychiatry, 52*, 679–687.

Miklowitz, D. J., George, E., L., Richards, J. A., Simoneau, T. L., & Suddath, R. L. (2003). A randomized study of family-focused psychoeducation and pharmacotherapy in the outconsumer management of bipolar disorder. *Archives of General Psychiatry, 60*, 904–912.

Miklowitz, D. J., & Goldstein, M. J. (1997). *Bipolar Disorder: A Family Focused Approach*. New York: Guilford Press.

Rea, M. M., Tompson, M. C., Miklowitz, D. G., Goldstein, M. J., Hwang, S., & Mintz, J. (2003). Family focused treatment versus individual treatment for bipolar disorder: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 71*(3), 482–492.

Sensky, T., Turkington, D., Kingdon, D., Scott, J. L., Scott, J., Siddle, R., O'Carroll, M., & Barnes, T. R. E. (2000). A randomised controlled trial of cognitive behavioural therapy for persistent symptoms in schizophrenia resistant to medication. *Archives of General Psychiatry, 57*, 165–172.

Sharif, Z., Bradford, D., Stroup, S., & Lieberman, J. (2007). Pharmacological treatment of schizophrenia. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 203–241). New York: Oxford University Press.

Tarrier, N., Kinney, C., McCarthy, E., Humphreys, L., Wittowski, A., & Morris, J. (2000). Two-year follow-up of cognitive behaviour therapy and supportive counseling in the treatment of persistent symptoms in chronic schizophrenia. *Journal of Consulting and Clinical Psychology, 68,* 917–922,

Tarrier, N., Kinney, C., McCarthy, E., Wittkowski, A., Yusupoff, Y., Gledhill, A., Morris, J., & Humphreys, L. (2001). The cognitive-behavioural treatment of persistent symptoms in chronic schizophrenia: Are some types of psychotic symptoms more responsive to cognitive-behaviour therapy? *Behavioural and Cognitive Psychotherapy, 29*, 45–56.

Tarrier, N., Wells, A., & Haddock, G. (1998). *Treating Complex Cases: The Cognitive Behavioural Therapy Approach.* Chichester, UK: John Wiley & Sons.

Tarrier, N., Wittkowski, A., Kinney, C., McCarthy, E., Morris, J., & Humphreys, L. (1999). The durability of the effects of cognitive behaviour therapy in the treatment of chronic schizophrenia: Twelve months follow-up. *British Journal of Psychiatry, 174*, 500–504.

Tarrier, N., Yusupoff, L., Kinney, C., McCarthy, E., Gledhill, A., Haddock, G., & Morris, J. (1998). A randomised controlled trial of intensive cognitive behaviour therapy for chronic schizophrenia. *British Medical Journal, 317*, 303–307.

Relapse Proneness

Marlatt, G. A., & Donovan, D. M. (Eds.) (2005). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors*, 2nd ed. New York: Guilford Press.

McGovern, M. P., & Carroll, K. M. (2003). Evidence-based practice for substance use disorders. *Psychiatric Clinics of North America*, *26,* 991–1010.

Miller, W. R., Wilbourne, P. L., & Hettema, J. E. (2003). What works? A summary of alcohol treatment outcome research. In R. K. Hester and W. R. Miller (Eds.), *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*, 3rd ed. (pp. 13–63). Boston: Allyn & Bacon.

Social Anxiety/Skills Deficit

Antony, M. M., & Swinson, R. P. (2000). *Phobic Disorders and Panic in Adults: A Guide to Assessment and Treatment*. Washington, D.C.: American Psychological Association.

Beidel, D. C., & Turner, S. M. (1998). *Shy Children, Phobic Adults: Nature and Treatment of Social Phobia*. Washington, D.C.: American Psychological Association.

Brown, T. A., DiNardo, P. A., & Barlow, D. H. (2006). *Anxiety Disorders Interview Schedule Adult Version (ADIS-IV): Client Interview Schedule.* New York: Oxford University Press.

Bruce, T. J., & Saeed, S. A. (1999). Social anxiety disorder: A common, underrecognized mental disorder. *American Family Physician, 60*(8), 2311–2320.

Chambless, D. L, Baker, M. J., Baucom, D., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., Daiuto, A., DeRubeis, R., Detweiler, J., Haaga, D. A. F., Johnson, S. B., McCurry, S., Mueser, K. T., Pope, K. S., Sanderson, W. C., Shoham, V., Stickle, T., Williams, D. A., & Woody, S. R. (1998). Update on Empirically Validated Therapies: II. *The Clinical Psychologist, 51*(1), 3–16.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*, 685–716.

Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia. In Heimberg, R. G., Liebowitz, M. R., et al. (Eds.), *Social Phobia: Diagnosis, Assessment, and Treatment* (pp. 69–93). New York: Guilford Press.

Cognitive Behavioral Group Therapy for Social Phobia. (Cost = $20.00). Contact: Social Phobia Program, Department of Psychology, Temple University. Weiss Hall, 1701 N. 13th Street, Philadelphia, PA 19122–6085. Telephone: (215) 204–1575, Fax: (215) 204–2155, E-mail: rheimber@nimbus. ocis. temple. edu.

Crozier, W. R., & Alden, L. E. (2001). *International Handbook of Social Anxiety: Concepts, Research and Interventions Relating to the Self and Shyness*. Hoboken, NJ: John Wiley & Sons.

Heimberg, R. G., & Becker, R. E. (2002). *Cognitive-Behavioral Group Therapy for Social Phobia: Basic Mechanisms and Clinical Strategies*. New York: Guilford Press.

Heimberg, R. G., Liebowitz, M. R., Hope, D. A., & Schneier, F. R. (Eds.) (1995). *Social Phobia: Diagnosis, Assessment, and Treatment*. New York: Guilford Press.

Hofmann, S. G., & DiBartolo, P. M. (2001). *From Social Anxiety to Social Phobia: Multiple Perspectives*. Needham Heights, MA: Allyn & Bacon.

Hope, D. A., Heimberg, R. G., Juster, H. R., & Turk, C. L. (2000). *Managing Social Anxiety*. Boulder, CO: Graywind Publications.

Mattick, R. P., & Clarke, J. C. (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. *Behaviour Research and Therapy, 36*, 455–470.

Rapee, R. M., & Sanderson, W. C. (1998). *Social Phobia: Clinical Application of Evidence-Based Psychotherapy*. Northvale, NJ: Jason Aronson.

Roy-Byrne, P. P. & Cowley, D. S. (2007). Pharmacological treatments for panic disorder, generalized anxiety disorder, specific phobia, and social anxiety disorder. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments That Work*, 3rd ed. (pp. 395–430). New York: Oxford University Press.

Schelver, S. R., & Gutsch, K. U., (1983). The effects of self-administered cognitive therapy on social-evaluative anxiety. *Journal of Clinical Psychology, 39*, 658–666.

Schmidt, L. A., & Schulkin, J. (Eds.) (1999). *Extreme Fear, Shyness and Social Phobia: Origins, Biological Mechanisms, and Clinical Outcomes*. New York: Oxford University Press.

Scholing, A. Emmelcamp, P., & Van Oppen, (1996). Cognitive Behavioral Treatment of Social Phobia. In V. B. Van Hasselt and M. Hersen (Eds.), *Sourcebook of Psychological Treatment Manuals for Adult Disorders*. New York: Plenum.

Stein, M. B. (Ed.) (1995). *Social Phobia: Clinical and Research Perspectives*. Washington, D. C.: American Psychiatric Press.

Turk, C., Heimberg, R. G., & Hope, D. A. (2001). Social Anxiety Disorder. In D. H. Barlow (Ed.), *Clinical Handbook of Psychological Disorders,* 3rd ed. New York: Guilford Press.

Turner, S. M., Beidel, D. C., & Cooley, M. (1997). *Social Effectiveness Therapy: A Program for Overcoming Social Anxiety and Phobia*. Toronto: Multi-Health Systems (U.S. telephone: (416) 424–1700, Fax: (416) 424–1736).

Substance Abuse/Dependence

Abbot, P. J., Weller, S. B., Delaney, H. D., & Moore, B. A. (1998). Community reinforcement approach in the treatment of opiate addicts. *American Journal of Drug and Alcohol Abuse, 24*(1), 17–30.

Drake, R. E., McHugo, G., & Noordsy, D. L. 1993). Treatment of alcoholism among schizophrenic outpatients: Four-year outcomes. *American Journal of Psychiatry*, *150,* 328–329.

Epstein, E. E., & McGrady, B. S. (1998). Behavioral couples treatment of alcohol and drug use disorders: Current status and innovations. *Clinical Psychology Review, 18*, 689–711.

Finney, J. W., Wilbourne, P. L., & Moos, R. H. (2007). Psychosocial treatments for substance use disorders. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 179–202). New York: Oxford University Press.

Marlatt, G. A., & Donovan, D. M. (Eds.) (2005). *Relapse prevention: Maintenance Strategies in the Treatment of Addictive Behaviors,* 2nd ed. New York: Guilford Press.

McCrady, B. S. (2001). Alcohol use disorders. In D. H. Barlow (Ed.), *Clinical Handbook of Psychological Disorders,* 3rd ed. New York: Guilford Press.

McGovern, M. P., & Carroll, K. M. (2003). Evidence-based practice for substance use disorders. *Psychiatric Clinics of North America, 26*, 991–1010.

Miller, W. R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change*, 2nd ed. New York: Guilford Press.

Miller, W. R., Wilbourne, P. L., & Hettema, J. E. (2003). What works? A summary of alcohol treatment outcome research. In R. K. Hester and W. R. Miller (Eds.), *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*, 3rd ed. (pp. 13–63). Boston: Allyn & Bacon.

Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice.* New York: Guilford Press.

O'Brien, C. P., & McKay J. (2007). Psychopharmacological treatments for substance use disorders. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments That Work*, 3rd ed. (pp. 145–177). New York: Oxford University Press.

O'Farrell, T. J., Choquette, K. A., & Cutter, H. S. G. (1998). Couples relapse prevention sessions after Behavioral Marital Therapy for male alcoholics: Outcomes during the three years after starting treatment. *Journal of Studies on Alcohol, 59*, 357–370.

O'Farrell, T. J., Choquette, K. A., Cutter H. S. G., Brown, E. D., & McCourt, W. F. (1993). Behavioral Marital Therapy with and without additional couples relapse prevention sessions for alcoholics and their wives. *Journal of Studies on Alcohol. 54,* 652–666.

Ouimette, P. C., Finney, J. W., & Moos, R. H. (1997). Twelve step and cognitive-behavioral treatment for substance abuse: A comparison of treatment effectiveness. *Journal of Consulting and Clinical Psychology, 65*, 230–240.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behavior. *American Psychologist, 47*(9), 1102–1114.

Project, MATCH Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol, 58*, 7–29.

Smith, J. E., Meyers, R. J., & Delaney, H. D. (1998). The community reinforcement approach with homeless alcohol-dependent individuals. *Journal of Consulting and Clinical Psychology, 66*, 541–548.

Suicidal Ideation

See "Borderline Traits" and "Depression" chapters in this *Planner*.

Treatment Resistance

Conners, G., Donovan, D., & DiClemente, C. (2004). *Substance Abuse Treatment and the Stages of Change: Selecting and Planning Interventions*. New York: Guilford Press.

Finney, J. W., Wilbourne, P. L., & Moos, R. H. (2007). Psychosocial treatments for substance use disorders. In P. E. Nathan and J. M. Gorman (Eds.), *A Guide to Treatments that Work*, 3rd ed. (pp. 179–202). New York: Oxford University Press.

McGovern, M. P., & Carroll, K. M. (2003). Evidence-based practice for substance use disorders. *Psychiatric Clinics of North America, 26,* 991–1010.

Miller, W. R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change,* 2nd ed. New York: Guilford Press.

Miller, W. R., Wilbourne, P. L., & Hettema, J. E. (2003). What works? A summary of alcohol treatment outcome research. In R. K. Hester and W. R. Miller (Eds.), Handbook of *Alcoholism Treatment Approaches: Effective Alternatives,* 3rd ed. (pp. 13–63). Boston: Allyn & Bacon.

Appendix C

INDEX OF *DSM-IV-TR* CODES ASSOCIATED WITH PRESENTING PROBLEMS

Acculturation Problem **V62.4**
Spiritual Confusion

Acute Stress Disorder **308.3**
Anxiety
Grief/Loss Unresolved

Adjustment Disorder **309.xx**
Posttraumatic Stress Disorder (PTSD)

Adjustment Disorder with Anxiety **309.24**
Medical Issues
Occupational Problem
Social Anxiety/Skills Deficit

Adjustment Disorder with Depressed Mood **309.0**
Depression
Grief/Loss Unresolved
Medical Issues
Occupational Problem
Suicidal Ideation

Adjustment Disorder with Disturbance of Conduct **309.3**
Antisocial Behavior
Grief/Loss Unresolved
Legal Problems
Medical Issues
Peer Group Negativity
Sexual Promiscuity

Adjustment Disorder with Mixed Anxiety and Depressed Mood **309.28**
Depression
Grief/Loss Unresolved
Social Anxiety/Skills Deficit

Adjustment Disorder with Mixed Disturbance of Emotions and Content **309.4**
Anger
Dangerousness/Lethality
Grief/Loss Unresolved
Oppositional Defiant Disorder
Peer Group Negativity

Adult Antisocial Behavior **V71.01**
Antisocial Behavior
Dangerousness/Lethality
Family Conflicts
Legal Problems

Alcohol Abuse **305.00**
Substance Abuse/Dependence
Treatment Resistance

Alcohol Dependence **303.90**
Self-Care Deficits—Secondary
Substance Abuse/Dependence
Treatment Resistance

Alcohol-Induced Anxiety Disorder **291.89**

Anxiety
Substance-Induced Disorders

Alcohol-Induced Mood Disorder **291.89**
Substance-Induced Disorders
Suicidal Ideation

Alcohol-Induced Persisting Amnestic Disorder **291.1**
Substance-Induced Disorders

Alcohol-Induced Persisting Dementia **291.2**
Self-Care Deficits—Secondary
Substance-Induced Disorders

Alcohol-Induced Psychotic Disorder **291.x**
Psychosis

Alcohol-Induced Psychotic Disorder, with Delusions **291.5**
Substance-Induced Disorders

Alcohol-Induced Psychotic Disorder, with Hallucinations **291.3**
Substance-Induced Disorders

Alcohol-Induced Sexual Dysfunction **291.8**
Substance-Induced Disorders

Alcohol-Induced Sleep Disorder **291.8**
Substance-Induced Disorders

Alcohol Intoxication **303.00**
Substance Intoxication/Withdrawal

Alcohol Intoxication Delirium **291.0**
Substance-Induced Disorders

Alcohol Withdrawal **291.8**
Substance Intoxication/Withdrawal

Alcohol Withdrawal Delirium **291.0**
Substance-Induced Disorders

Amphetamine Abuse **305.70**
Substance Abuse/Dependence
Treatment Resistance

Amphetamine Dependence **304.40**
Substance Abuse/Dependence
Treatment Resistance

Amphetamine-Induced Mood Disorder **292.84**
Suicidal Ideation

Amphetamine Intoxication **292.89**
Substance Intoxication/Withdrawal

Amphetamine Withdrawal **292.0**
Substance Intoxication/Withdrawal

Anorexia Nervosa **307.1**
Eating Disorders

Antisocial Personality Disorder **301.7**
Anger
Antisocial Behavior
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adolescent
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adult
Attention-Deficit/Inattentive Disorder (ADD)
Borderline Traits
Childhood Trauma
Dangerousness/Lethality
Family Conflicts
Impulsivity
Legal Problems
Occupational Problem
Oppositional Defiant Disorder
Parent-Child Relational Problem
Partner Relational Conflicts
Peer Group Negativity
Relapse Proneness
Sexual Promiscuity
Treatment Resistance

Anxiety Disorder, Not Otherwise Specified **300.00**
Adult-Child-of-an-Alcoholic (ACOA) Traits
Dependent Traits

Attention-Deficit/Hyperactivity Disorder **314**
Impulsivity
Relapse Proneness

Attention-Deficit/Hyperactivity Disorder, Combined Type **314.01**
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adolescent
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adult
Attention-Deficit/Inattentive Disorder (ADD)

Attention-Deficit/Hyperactivity Disorder, Not Otherwise Specified **314.9**

Attention-Deficit/Hyperactivity Disorder (ADHD)—Adolescent
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adult
Attention-Deficit Inattentive Disorder (ADD)
Conduct Disorder/Delinquency

Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type 314.01
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adolescent
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adult
Conduct Disorder/Delinquency

Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type 314.00
Attention-Deficit/Inattentive Disorder (ADD)

Avoidant Personality Disorder 301.82
Adult-Child-of-an-Alcoholic (ACOA) Traits
Anxiety
Dependent Traits
Peer Group Negativity
Relapse Proneness
Social Anxiety/Skills Deficit

Bereavement V62.82
Depression
Grief/Loss Unresolved

Bipolar Disorder, Not Otherwise Specified 296.80
Mania/Hypomania

Bipolar I Disorder 296.xx
Anger
Borderline Traits
Dangerousness/Lethality
Depression
Gambling
Mania/Hypomania
Narcissistic Traits
Oppositional Defiant Disorder
Psychosis
Relapse Proneness
Self-Care Deficits—Primary
Self-Care Deficits—Secondary
Sexual Promiscuity
Suicidal Ideation

Bipolar I Disorder, Most Recent Episode Manic 296.4x
Impulsivity

Bipolar II Disorder 296.89
Anger
Borderline Traits
Dangerousness/Lethality
Depression
Gambling
Impulsivity
Mania/Hypomania
Narcissistic Traits
Oppositional Defiant Disorder
Relapse Proneness
Self-Care Deficits—Primary
Self-Care Deficits—Secondary
Sexual Promiscuity
Suicidal Ideation

Borderline Personality Disorder 301.83
Anger
Antisocial Behavior
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adolescent
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adult
Borderline Traits
Childhood Trauma
Dangerousness/Lethality
Depression
Family Conflicts
Impulsivity
Legal Problems
Narcissistic Traits
Peer Group Negativity
Posttraumatic Stress Disorder (PTSD)
Relapse Proneness
Sexual Promiscuity
Social Anxiety/Skills Deficit
Suicidal Ideation

Brief Psychotic Disorder 298.8
Psychosis

Bulimia Nervosa 307.51
Eating Disorders

Caffeine Intoxication 305.90
Substance Intoxication/Withdrawal

Cannabis Abuse 305.20
Substance Abuse/Dependence
Treatment Resistance

Cannabis Dependence 304.30
Substance Abuse/Dependence
Treatment Resistance

Cannabis Intoxication 292.89
Substance Intoxication/Withdrawal

Child or Adolescent Antisocial Behavior V71.02
Antisocial Behavior
Oppositional Defiant Disorder

Cocaine Abuse 305.60
Substance Abuse/Dependence
Treatment Resistance

Cocaine Dependence 304.20
Substance Abuse/Dependence
Treatment Resistance

Cocaine-Induced Mood Disorder 292.84
Suicidal Ideation

Cocaine Intoxication 292.89
Substance Intoxication/Withdrawal

Cocaine Withdrawal 292.0
Substance Intoxication/Withdrawal

Cognitive Disorder, Not Otherwise Specified 294.9
Medical Issues

Conduct Disorder 312.8
Anger
Antisocial Behavior
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adolescent
Attention-Deficit/Inattentive Disorder (ADD)
Dangerousness/Lethality
Family Conflicts
Impulsivity
Legal Problems
Oppositional Defiant Disorder
Peer Group Negativity
Relapse Proneness
Sexual Promiscuity

Conduct Disorder, Adolescent-Onset Type 312.82
Conduct Disorder/Delinquency

Conduct Disorder, Childhood-Onset Type 312.81
Conduct Disorder/Delinquency

Conversion Disorder 300.11
Chronic Pain

Cyclothymic Disorder 301.13
Depression
Impulsivity
Mania/Hypomania
Narcissistic Traits
Relapse Proneness

Delusional Disorder 297.1
Psychosis
Self-Care Deficits—Primary
Self-Care Deficits—Secondary

Dependent Personality Disorder 301.6
Adult-Child-of-an-Alcoholic (ACOA) Traits
Anxiety
Dependent Traits
Eating Disorders
Family Conflicts
Social Anxiety/Skills Deficit

Depersonalization Disorder 300.6
Posttraumatic Stress Disorder (PTSD)

Depressive Disorder, Not Otherwise Specified 311
Adult-Child-of-an-Alcoholic (ACOA) Traits
Depression
Grief/Loss Unresolved
Occupational Problem

Disruptive Behavior Disorder, Not Otherwise Specified 312.9
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adolescent
Attention-Deficit/Inattentive Disorder (ADD)
Conduct Disorder/Delinquency

Dissociative Disorder, Not Otherwise Specified 300.15
Posttraumatic Stress Disorder (PTSD)

Dissociative Identity Disorder 300.14
Childhood Trauma
Posttraumatic Stress Disorder (PTSD)

Dysthymic Disorder 300.4
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adult
Borderline Traits
Childhood Trauma
Depression
Eating Disorders
Social Anxiety/Skills Deficit
Suicidal Ideation

Eating Disorder, Not Otherwise Specified 307.50
Eating Disorders

Generalized Anxiety Disorder 300.02
Anxiety
Childhood Trauma
Dependent Traits
Occupational Problem
Social Anxiety/Skills Deficit

Hallucinogen Abuse 305.30
Substance Abuse/Dependence
Treatment Resistance

Hallucinogen Dependence 304.50
Substance Abuse/Dependence
Treatment Resistance

Hallucinogen Intoxication 292.89
Substance Intoxication/Withdrawal

Histrionic Personality Disorder 301.50
Anxiety
Dependent Traits
Eating Disorders
Narcissistic Traits

Hypochondriasis 300.7
Medical Issues

Identity Problem 313.82
Borderline Traits

Impulse-Control Disorder, Not Otherwise Specified 312.30
Anger
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adolescent
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adult
Attention-Deficit/Inattentive Disorder (ADD)
Gambling
Impulsivity
Oppositional Defiant Disorder
Sexual Promiscuity

Inhalant Abuse 305.90
Substance Abuse/Dependence
Treatment Resistance

Inhalant Dependence 304.60
Substance Abuse/Dependence
Treatment Resistance

Inhalant-Induced Mood Disorder 292.84
Suicidal Ideation

Intermittent Explosive Disorder 312.34
Anger
Antisocial Behavior
Conduct Disorder/Delinquency
Dangerousness/Lethality
Impulsivity
Legal Problems
Oppositional Defiant Disorder

Learning Disorder, Not Otherwise Specified 315.9
Attention-Deficit/Inattentive Disorder (ADD)

Major Depressive Disorder 296.xx
Borderline Traits
Childhood Trauma
Dangerousness/Lethality
Eating Disorders
Psychosis
Suicidal Ideation

Major Depressive Disorder, Recurrent 296.3x
Chronic Pain
Depression
Grief/Loss Unresolved

Major Depressive Disorder, Single Episode 296.2x
Depression
Grief/Loss Unresolved

Maladaptive Health Behaviors Affecting *[Axis III Disorder]* 316
Medical Issues

Mild Mental Retardation 317
Self-Care Deficits—Primary
Self-Care Deficits—Secondary

Mood Disorder Due to . . . *[Indicate the General Medical Condition]* 293.83

Narcissistic Personality Disorder 301.81
Anger
Antisocial Behavior
Dangerousness/Lethality
Impulsivity
Legal Problems
Narcissistic Traits
Parent-Child Relational Problem
Partner Relational Conflicts
Peer Group Negativity

Relapse Proneness
Sexual Promiscuity

Neglect of Child **V61.4**
Childhood Trauma
Living Environment Deficiency
Parent-Child Relational Problem

Neglect of Child (if focus of clinical attention is on the victim) **995.5**
Childhood Trauma
Living Environment Deficiency

Nicotine Dependence **305.10**
Nicotine Abuse/Dependence

Nicotine Withdrawal **292.0**
Nicotine Abuse/Dependence

Obsessive-Compulsive Disorder **300.3**
Anxiety
Eating Disorders

Occupational Problem **V62.2**
Living Environment Deficiency
Occupational Problem

Opioid Abuse **305.50**
Opioid Dependence
Substance Abuse/Dependence
Treatment Resistance

Opioid Dependence **304.00**
Chronic Pain
Opioid Dependence
Substance Abuse/Dependence
Treatment Resistance

Opioid-Induced Mood Disorder **292.84**
Suicidal Ideation

Opioid Intoxication **292.89**
Opioid Dependence
Substance Intoxication/Withdrawal

Opioid-Related Disorder, Not Otherwise Specified **292.9**
Opioid Dependence

Opioid Withdrawal **292.0**
Opioid Dependence
Substance Intoxication/Withdrawal

Oppositional Defiant Disorder **313.81**
Anger
Antisocial Behavior
Attention-Deficit/Hyperactivity Disorder (ADHD)—Adolescent
Attention-Deficit/Inattentive Disorder (ADD)
Conduct Disorder/Delinquency
Dangerousness/Lethality
Family Conflicts
Impulsivity
Legal Problems
Oppositional Defiant Disorder
Parent-Child Relational Problem
Relapse Proneness

Other Substance Induced Disorder **292.xx**
Psychosis

Other (or Unknown) Substance Intoxication **292.81**
Substance Intoxication/Withdrawal

Other (or Unknown) Substance Withdrawal **292.0**
Substance Intoxication/Withdrawal

Pain Disorder Associated with Both Psychological Factors and an Axis III Disorder **307.89**
Chronic Pain
Medical Issues

Pain Disorder Associated with Psychological Factors **307.80**
Chronic Pain
Medical Issues

Panic Disorder with Agoraphobia **300.21**
Anxiety
Dependent Traits
Social Anxiety/Skills Deficit

Panic Disorder without Agoraphobia **300.01**
Anxiety
Social Anxiety/Skills Deficit

Paranoid Personality Disorder **301.0**
Anger
Borderline Traits
Dangerousness/Lethality
Occupational Problem
Social Anxiety/Skills Deficit

Parent-Child Relational Problem V61.20
Adult-Child-of-an-Alcoholic (ACOA) Traits
Conduct Disorder/Delinquency
Dependent Traits
Family Conflicts
Living Environment Deficiency
Parent-Child Relational Problem

Partner Relational Problem V61.1
Family Conflicts
Living Environment Deficiency
Partner Relational Conflicts

Pathological Gambling 312.31
Gambling

Pedophilia 302.2
Sexual Promiscuity

Personality Disorder, Not Otherwise Specified 301.9
Adult-Child-of-an-Alcoholic (ACOA) Traits
Anger
Dependent Traits
Depression
Posttraumatic Stress Disorder (PTSD)

Personality Traits Affecting *[Axis III Disorder]* 316
Medical Issues

Phase of Life Problem V62.89
Occupational Problem

Phencyclidine Abuse 305.90
Substance Abuse/Dependence
Treatment Resistance

Phencyclidine Dependence 304.90
Substance Abuse/Dependence
Treatment Resistance

Phencyclidine Intoxication 292.89
Substance Intoxication/Withdrawal

Physical Abuse of Adult V61.10
Living Environment Deficiency
Partner Relational Conflict

Physical Abuse of Child V61.21
Childhood Trauma
Living Environment Deficiency
Parent-Child Relational Problem

Physical Abuse of Child (if focus of clinical attention is on victim) 995.5
Childhood Trauma
Living Environment Deficiency
Posttraumatic Stress Disorder (PTSD)

Physical/Sexual Abuse of Adult (if focus of clinical attention is on victim) 995.81
Living Environment Deficiency
Partner Relational Conflicts

Polysubstance Dependence 304.80
Chronic Pain
Opioid Dependence
Relapse Proneness
Self-Care Deficits—Secondary
Substance Abuse/Dependence
Treatment Resistance

Posttraumatic Stress Disorder 309.81
Adult-Child-of-an-Alcoholic (ACOA) Traits
Childhood Trauma
Posttraumatic Stress Disorder (PTSD)

Psychological Symptoms Affecting *[Axis III Disorder]* 316
Medical Issues

Psychotic Disorder, Not Otherwise Specified 298.9

Relational Problem, Not Otherwise Specified V62.81
Living Environment Deficiency
Occupational Problem
Parent-Child Relational Problem
Partner Relational Conflicts

Religious or Spiritual Problem V62.89
Spiritual Confusion

Schizoaffective Disorder 295.70
Depression
Mania/Hypomania
Self-Care Deficits—Primary
Self-Care Deficits—Secondary

Schizoid Personality Disorder 301.20
Parent-Child Relational Problem
Partner Relational Conflicts
Relapse Proneness

Schizophrenia 295.xx
Psychosis
Self-Care Deficits—Primary
Self-Care Deficits—Secondary

Schizophrenia, Disorganized Type **295.10**
Self-Care Deficits—Primary

Schizophrenia, Paranoid Type **295.30**
Self-Care Deficits—Primary

Schizophrenia, Residual Type **295.60**
Self-Care Deficits—Primary

Schizophrenia, Undifferentiated Type **295.90**
Self-Care Deficits—Primary

Schizophreniform Disorder **295.40**
Psychosis

Sedative, Hypnotic, or Anxiolytic Abuse **305.40**
Substance Abuse/Dependence
Treatment Resistance

Sedative, Hypnotic, or Anxiolytic Dependence **304.10**
Chronic Pain
Substance Abuse/Dependence
Treatment Resistance

Sedative, Hypnotic, or Anxiolytic Intoxication **292.89**
Substance Intoxication/Withdrawal

Sedative, Hypnotic, or Anxiolytic Withdrawal **292.0**
Substance Intoxication/Withdrawal

Separation Anxiety Disorder **309.21**
Anxiety

Sexual Abuse of Adult **V61.10**
Living Environment Deficiency
Partner Relational Conflicts
Posttraumatic Stress Disorder (PTSD)

Sexual Abuse of Adult (by person other than partner) **V62.83**
Posttraumatic Stress Disorder (PTSD)

Sexual Abuse of Child **V61.21**
Childhood Trauma
Living Environment Deficiency
Parent-Child Relational Problem
Posttraumatic Stress Disorder (PTSD)

Sexual Abuse of Child (if focus of clinical attention is on the victim) **995.53**
Childhood Trauma
Posttraumatic Stress Disorder (PTSD)

Sibling Relational Problem **V61.8**
Family Conflicts
Living Environment Deficiency

Social Phobia **300.23**
Anxiety
Dependent Traits
Social Anxiety/Skills Deficit

Somatization Disorder **300.81**
Chronic Pain
Medical Issues

Substance-Induced Anxiety Disorder **292.89**
Social Anxiety/Skills Deficit

Appendix D

CLIENT SATISFACTION SURVEYS: RESOURCE MATERIAL

Each chapter in the book has a list of Objectives and Interventions; at the end of the list they refer to completing or administering a satisfaction survey. Following are listed references to examples of surveys that may be purchased and used for assessing client satisfaction. Dr. C. Attkisson has published considerable research on this issue, and others have used his scales in their research and agency outcome studies. Attkisson has developed scales with 3, 4, 8, 18, and 31 items.

Other surveys are also used in gathering information about clients' satisfaction with mental health services. The following are references to survey material. Some of this material is copyrighted and must be purchased, while other survey items are available for general use. Please contact the authors to ask about using their survey material.

Attkisson, C., & Pascoe, G. (1983). Patient satisfaction in health and human services. *Evaluation and Program Planning, 6*(3), 373–383.

Eisen, S. V., Shaul, J. A., Leff, H. S., Stringfellow, V., Clarridge, B. R., & Cleary, P. D. (2001). Toward a national consumer survey: Evaluation of the CABHS and MHSIP instruments. *Journal of Behavioral Health Services & Research, 28*(3), 347–369.

Essex, D. W., Fox, J. A., & Groom, J. M. (1981). The development, factor analysis, and revision of a client satisfaction form. *Community Mental Health Journal, 17*(3), 226–235.

Greenfield, T., & Attkisson, C. (1989). Steps toward a multifactorial satisfaction scale for primary care and mental health service. *Evaluation and Program Planning, 12,* 271–278.

Larson, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction in human service programs: Development of a general scale. *Evaluation and Program Planning, 2,* 197–207.

Lebow, J., (1983). Research assessing consumer satisfaction with mental health treatment: A review of findings. *Evaluation and Program Planning, 6,* 237–245.

Mental Health Corporations of America. (1995). *Customer Survey–Form C.* Tallahassee, FL: Mental Health Corporations of America.

Appendix E

ASAM SIX ASSESSMENT DIMENSIONS: A CHECKLIST EXAMPLE

Dimension 1: Detoxification/Withdrawal (Acute Intoxication/Withdrawal Potential)

Signs and symptoms indicate the continued presence of the intoxication or withdrawal problem that required admission to the present level of care.

- □ Patient was monitored for acute withdrawal symptoms and received medication(s).
- □ Patient was monitored for acute withdrawal symptoms and did not receive medication for withdrawal.
- □ Patient completed acute detoxification and no complications were noted.
- □ Patient completed acute detoxification and withdrawal was prolonged.
- □ Patient received education on protracted withdrawal symptoms.
- □ Patient did not require detoxification at the time of admission.

COMMENTS: _____

Dimension 2: Biomedical Conditions and Complications

The patient's status in Dimension 2 is characterized by *one* of the following:

YES	NO		
_____	_____	a.	The interaction of the patient's biomedical condition and continued alcohol or other drug use places the patient in imminent danger of serious damage to physical health or concomitant biomedical conditions; *or*
_____	_____	b.	A current biomedical condition requires 24-hour nursing and medical monitoring or active treatment.

Patient was treated for the following medical problems

❑ Hypertension	❑ Chronic Pain Syndrome	❑ Sleep Pattern Disturbance	❑ Hepatomegaly
❑ COPD/Asthma/ Emphysema	❑ Diabetes	❑ Cardiovascular Problems	❑ Headaches
❑ Back Problems	❑ Anemia	❑ Pancreatitis	❑ Arthritis/Gout
❑ Upper Respiratory Infection	❑ Thyroid Problems	❑ Bowel Problems	❑ Ulcers
❑ Gastritis	❑ Urinary Tract Infection	❑ GERD	❑ Sinus Infection
			❑ Hepatitis

□ Other _____

□

□ Admission Laboratory Work Completed □ Repeat Laboratory Work Completed □. N/A □ Urine Chemical Screening Completed: □ Positive □ Negative □ Not Available at the Present Time

□ History and Physical Completed □ TB Mantoux Given: □ Positive □ Negative

□ Patient was given psychotropic medications—see Dimension 3 for further information.

COMMENTS: _____

Dimension 3: Emotional/Behavioral Conditions and Complications

Affect or Mood (Check all that are appropriate):

❑ Appropriate	❑ Labile	❑ Restless	❑ Poor Impulse Control
❑ Euphoric	❑ Cooperative	❑ Pressured Speech	❑ Anxious
❑ Sad	❑ Homicidal Plan	❑ Manic	❑ Angry
❑ Homicidal Ideation	❑ Panic Attacks	❑ Flat	❑ Suicidal Plan
❑ Poor Concentration	❑ Apathetic	❑ Suicidal Ideation	❑ Depressed
❑ Requires Ongoing Boundary Setting	❑ Aggressive	❑ Paranoid Thoughts	
❑ Inappropriate	❑ Argumentative	❑ Obsessive-Compulsive Thoughts	
	❑ Irritable		

Patient had a psychiatric evaluation by a psychiatrist:
□ Yes □ No □ Scheduled but Pending
Patient received a prescription for psychotropic medications:
□ Yes □ No
Medications were prescribed for the following psychiatric conditions:

_____

COMMENTS: _____

Dimension 4: Readiness to Change

The patient's status in this dimension is characterized by *one* of the following:

YES	NO		
_____	_____	a.	Despite experiencing serious consequences or effects of the addictive disorder or mental health problem, the patient does not accept or relate the addictive disorder to the severity of these problems; *or*
_____	_____	b.	The patient is in need of intensive strategies, activities, and processes available only in a 24-hour structured, medically monitored setting; *or*
_____	_____	c.	The patient needs ongoing, 24-hour psychiatric monitoring to assure follow-through with the treatment regimen and to deal with issues such as ambivalence about compliance with psychiatric medications.

Attendance: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Attitude: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Group Participation: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Honesty: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Acceptance: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Commitment/Motivation: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

During the past week the patient worked on the following assignments (Check all that apply):

Chemical Use History ☐ Problem Assessment ☐ Millon ☐ Quickview ☐ BECK Depression Inventory ☐ Honesty Exercise ☐ Step One ☐ Step Two ☐ Step Three ☐ Step Four ☐ Step Five ☐ Gambling Assessments ☐ Other _____

Patient Visited with Staff Clergy: ☐ Yes ☐ No
Patient Attended Church: ☐ Yes ☐ No

COMMENTS: _____

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

The patient's status in this dimension is characterized by *one* of the following:

YES	NO		
_____	_____	a.	The patient is experiencing an acute psychiatric or substance-use crisis, marked by intensification of symptoms of his/her addictive or mental disorder, *or*
_____	_____	b.	The patient is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, *or*
_____	_____	c.	The modality of treatment or protocols to address relapse require that the patient stay in treatment.

Relapse Potential is: ☐ High ☐ Moderate ☐ Low
Worked on a Peer Pressure Exercise: ☐ Yes ☐ No ☐ Pending
Worked on Identifying Relapse Triggers: ☐ Yes ☐ No ☐ Pending
Developed a Relapse Prevention Exercise: ☐ Yes ☐ No ☐ Pending
Patient Has Pending Legal Issues: ☐ Yes ☐ No ☐ Pending
Had Contact with Patient's Probation Officer: ☐ Yes ☐ No ☐ Pending ☐ N/A

COMMENTS: _____

Dimension 6: Recovery Environment

The patient's status in this dimension is characterized by *one* of the following:

YES	NO		
_____	_____	a.	The patient's current living situation is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse, or substance use so endemic that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care; *or*
_____	_____	b.	Family members or significant others living with the patient are not supportive of his/her recovery goals and are actively sabotaging treatment; *or*
_____	_____	c.	The patient is unable to cope, for even limited periods of time.

It is appropriate to retain the patient at the present level of care if:

_____ 1. The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his/her treatment goals; *or*

_____ 2. The patient is not yet making progress, but has the capacity to resolve his/her problems. He/she is actively working toward the goals articulated in his/her individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his/her treatment goals; *and/or*

_____ 3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the patient's new problems can be addressed effectively.

Patient Developed a Relapse Prevention Plan:
☐ Yes ☐ No ☐ Pending
Patient Agreed to Participate in AA/NA/GA Meetings Post Discharge:
☐ Yes ☐ No
Patient Given a Name for a Temporary AA/NA/GA Contact:
☐ Yes ☐ No ☐ Pending
Patient Agreed to Attend Aftercare Meetings Post Discharge:
☐ Yes ☐ No ☐ Pending
If Yes, At What Facility: _____
Patient Has Agreed to Attend Individual Counseling Post Discharge:
☐ Yes ☐ No ☐ Pending ☐ N/A ☐ Patient Refuses
If Yes, At What Facility: _____
Patient Has Agreed to Attend Marital Counseling Post Discharge:
☐ Yes ☐ No ☐ Pending ☐ N/A ☐ Patient Refuses
If Yes, At What Facility: _____
Employer Has Been Contacted:
☐ Yes ☐ No ☐ Pending ☐ N/A ☐ Patient Refuses
Family/Significant Other was Contacted:
☐ Yes ☐ No ☐ Pending ☐ N/A ☐ Patient Refuses
Family Program Scheduled:
☐ Yes (Dates_____) ☐ No ☐ Pending ☐ Patient Refuses
Halfway House Placement Is Being Recommended for the Patient:
☐ Yes ☐ No ☐ Pending ☐ N/A ☐ Patient Refuses
Patient Returning Home:
☐ Yes ☐ No ☐ Pending ☐ N/A ☐ Patient Refuses

COMMENTS: _____

_____ ____

Primary Therapist Signature Date